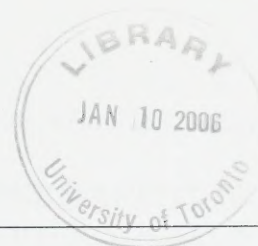


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Monday 5 December 2005

Journal des débats (Hansard)

Lundi 5 décembre 2005

**Standing committee on
social policy**

Child and Family Services
Statute Law
Amendment Act, 2005

**Comité permanent de
la politique sociale**

Loi de 2005 modifiant des lois
en ce qui concerne les services
à l'enfance et à la famille

Chair: Mario G. Racco
Clerk: Anne Stokes

Président : Mario G. Racco
Greffière : Anne Stokes

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 5 December 2005

Lundi 5 décembre 2005

The committee met at 1600 in room 151.

SUBCOMMITTEE REPORT

The Chair (Mr. Mario G. Racco): Good afternoon and welcome to the meeting of the standing committee on social policy in consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts.

Our first order of business before we commence the public hearings is a motion for adoption of the subcommittee report.

Ms. Kathleen O. Wynne (Don Valley West): Mr. Chair, I'd like to move the subcommittee report.

The Chair: Thank you. Can you please read it?

Ms. Wynne: Yes. Your subcommittee considered on Monday, November 28, and Thursday, December 1, 2005, the method of proceeding on Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts, and recommends the following:

(1) That the committee meet for the purpose of public hearings on Bill 210 on Monday, December 5; Tuesday, December 6; Monday, December 12; and Tuesday, December 13, 2005, in Toronto.

(2) That the clerk of the committee be authorized prior to passage of the subcommittee report to place an advertisement on the Ont.Parl channel, the Legislative Assembly Web site and in a press release regarding the proposed meeting dates on December 5 and 6, 2005.

(3) That the deadline for those who wish to make an oral presentation on Bill 210 be 5 p.m. on Thursday, December 1, 2005.

(4) That the deadline for written submissions on Bill 210 be 6 p.m. on Tuesday, December 13, 2005.

(5) That the time to be allotted to organizations and individuals in which to make their presentations be determined by the Chair in consultation with the clerk depending on the number of requests received.

(6) That the Minister of Children and Youth Services be invited to make a 15-minute statement to the committee on December 5, 2005, and that the two opposition critics share 15 minutes in which to respond to the minister.

(7) That the clerk be authorized to schedule groups and individuals in consultation with the Chair, and that, if there are more witnesses wishing to appear than time

available, the clerk will provide the subcommittee members with the list of witnesses, and each caucus will then provide the clerk with a prioritized list of witnesses to be scheduled.

(8) That the research officer provide the committee with a summary of witness presentations as soon as possible after the conclusion of public hearings.

(9) That the committee provide the choice of video conferencing, teleconferencing or the payment of reasonable travel expenses to witnesses in order to accommodate those who are unable to travel to Toronto or need to travel to Toronto in order to make a presentation.

(10) That the clerk of the committee, in consultation with the Chair, be authorized prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair: Thank you. Do you have any comments?

Mr. Jeff Leal (Peterborough): I do want to get on the record. I want to commend you, Mr. Chair; the clerk, Ms. Stokes; and Minister Chambers. I had the opportunity last Friday to meet with Chris McCormick, who is the Deputy Grand Chief of the Association of Iroquois and Allied Indians, and Chief Greg Cowie, who is the Chief of Hiawatha First Nation community, which is in my riding of Peterborough. They indicated to me that because the Ontario association of chiefs is meeting in Ottawa today and tomorrow and they couldn't be present to make a delegation, they are very pleased that committee hearings will be held next week, affording them the opportunity to make a presentation. I just want to get that on the record and commend everybody involved in understanding the sensitivity of the First Nations community of Ontario on this issue.

The Chair: Thank you. Of course, all three parties agreed.

Are there any comments on the motion on the floor? Just for you, Mr. Hampton, we read the subcommittee report. We are debating and then voting on it. Mr. Arnott, please.

Mr. Ted Arnott (Waterloo-Wellington): Thank you, Mr. Chair. The subcommittee report indicates that the clerk would be "authorized to schedule groups and individuals in consultation with the Chair." I'm just looking at the list of presenters here today and tomorrow, and I see that the Ombudsman is scheduled to make a presentation tomorrow afternoon at 5:30 p.m. and he is being given 15 minutes.

The Ombudsman, of course, is an independent, neutral, non-partisan officer of the Legislature. I would think that it might be a good idea for the committee to allow the Ombudsman additional time. I was wondering if the government is prepared to consider that or—

The Chair: Thank you for your comments. What I was going to do was deal with today's agenda and, at the end of the meeting, the subcommittee or all of us can stay and make that decision. I think that's going to be part of the agenda at the end of this meeting, to discuss that possibility. That's my understanding, and I believe there's an agreement about that. So if we can leave it until the end of the meeting, that will be discussed.

Mr. Arnott: Thank you.

The Chair: Any other questions and comments on the motion? If there are none, may I then take a vote? All in favour? Those opposed? That carries.

CHILD AND FAMILY SERVICES
STATUTE LAW AMENDMENT ACT, 2005
LOI DE 2005 MODIFIANT DES LOIS
EN CE QUI CONCERNE LES SERVICES
À L'ENFANCE ET À LA FAMILLE

Consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts / Projet de loi 210, Loi modifiant la Loi sur les services à l'enfance et à la famille et apportant des modifications complémentaires à d'autres lois.

MINISTRY OF CHILDREN
AND YOUTH SERVICES

The Chair: The first item on the agenda is the opening statement from our minister, Madam Chambers, please.

Hon. Mary Anne V. Chambers (Minister of Children and Youth Services): Thank you, Chair. I'm very pleased to bring forward Bill 210 to the committee for review and consideration. This bill, if passed, would strengthen our ability to protect and help our most vulnerable children and youth. It would build upon existing strengths of the system and introduce mechanisms to make the current system even better.

Children in need of protection face significant challenges, and I think we all recognize that we have a collective responsibility to protect them from harm and to support them as they work to overcome their challenges. Our government understands that we cannot use a one-size-fits-all solution when dealing with the complex needs of children and their families.

This bill, if passed, would help more children who are crown wards and in the care of our children's aid societies find permanent supportive homes by making adoption more flexible for children and less complicated for prospective parents. We are also providing more options to enable more children to grow up in secure

family settings. As well, we are changing the way children's aid societies work by not only making them more stable and sustainable, but also making them more accountable to the children and families they serve, to our community partners and to government.

The child protection system deals with tremendous challenges every day, and I commend all the dedicated individuals who work in this field and who support children and their families. I think most would agree that the system is in need of reform. The system is faced with numerous pressures that can make it difficult to manage the conflicting demands. Throughout this process, we have worked closely with a wide range of stakeholders, including families, to develop legislation that will make the system work better for everyone: for the children it is meant to protect, for the families it is meant to assist and for the staff who are so dedicated to our young people.

Currently, Ontario's children's aid societies receive almost 160,000 calls reporting child abuse and neglect each year. Consider that these could be children who may be regularly left alone to fend for themselves, children who defend their mothers against abuse and suffer the consequences, children who are sexually assaulted by someone they trust and then live in silence, or children whose self-worth is routinely diminished to the extreme by others.

In many of the situations where a children's aid society is called, child protection staff can support parents so they are better able to care for their children. Experienced social workers and judges must sometimes make difficult decisions based on what they believe to be in the best interests of the child. The best interests and safety of the child is the driving force behind this legislation. Every one of the proposed reforms that we are bringing forward has been considered from the vantage point of the child. Our goal is to help every child in Ontario have the best opportunity to succeed and to reach their own potential.

There are about 9,000 children in the permanent care of Ontario's children's aid societies. They live in foster homes or in group homes. On average, they change homes every 22 months, and they change schools. They have to try and make new friends in a new neighbourhood. A new foster family or group home can mean new rules and new expectations. That kind of instability can affect every part of a child's life.

Of the 9,000 children who are crown wards of children's aid societies, we're seeing just over 900 adoptions a year. I think we can do better than that; we must do better than that. We need to help more children find a permanent, caring home by making adoption more flexible for individual children and parents.

1610

These proposed changes would remove the rigid restriction that a child must completely sever all ties to his or her birth family before being eligible for adoption. Right now, 75% of children in permanent care cannot be adopted because their birth family has a court-ordered right to contact them. When judges make an order that a

child becomes a ward of the state, they may be hesitant to seal off all contact with the family, except in those cases where it's necessary for the child's protection. So the birth family might have the opportunity to visit the child, say, twice a year. That often makes sense so the child doesn't completely lose touch with their birth family, but it should not automatically make the child ineligible to become a member of a permanent family. These proposed changes would mean that, where appropriate, a child could keep those important ties to their family, community and culture, and still be adopted or placed in a permanent home.

We know that adoption will help a number of children find a secure, stable family. But we also know it is not the answer for every child. Proposed changes would give children's aid societies more flexibility to meet the unique needs of each child. For some children, it would mean being placed with extended family, people they already know and trust. Under the current system, most children who are removed from their homes are placed in foster care or in a group home. Under our proposed new system, the children's aid society will have the option to place that child with a suitable member of their extended family. It could mean less disruption in the life of a child who has already been through too much. I would like to point out that even as Bill 210 is moving through the legislative process, I have asked my ministry to immediately develop a regulation to address situations where a child may be placed with extended family or a community member.

The process must always start with a rigorous safety and risk assessment for all children and families. The completion of an appropriate assessment, including background checks, is a critical safeguard in such situations. We know that not all children have a family member who is an appropriate caregiver. In such cases, there will often be other adults willing and able to provide a loving, stable home. It could actually be the child's long-time foster parent.

We are also working closely with the aboriginal community on a renewed emphasis on customary care that would allow more aboriginal children and youth to stay in their communities. I am committed to addressing their concerns, and have had several meetings with members of First Nations communities from across Ontario. I recently met with a group of chiefs and some operational staff to hear their concerns. I was with them for the better part of a full day. I listened to what they had to tell me about the issues First Nations face in the area of child protection and the Child and Family Services Act as it currently stands. They want to ensure that Bill 210 does not perpetuate the removal of their kids from their communities. I respect and appreciate their knowledge and traditions, and look forward to continued discussions with them to support their children.

This is particularly important because we know that aboriginal children are disproportionately represented in our child protection system. This is a trend that cannot continue. Under the current system, aboriginal children

who come into the care of a children's aid society are often placed in non-aboriginal foster care. With an emphasis on customary care, we will work with aboriginal leaders to build capacity so children can stay in their communities and maintain important cultural and family ties, as well as incorporating First Nations traditions into their upbringing. I will continue to work with aboriginal leaders to ensure that Bill 210 meets the needs of their children and their communities.

The proposed changes that I've discussed here are part of our government's plan to help more children and youth in the care of children's aid societies thrive in a safe, stable, supportive home.

We're also removing some of the barriers that often discourage people from adopting children in Ontario. Parents who have tried to adopt a child from a children's aid society will tell you it's a cumbersome, inconsistent process. We are improving the application process so there is a standard, consistent application for both public and private adoptions. This will make the process simpler for those parents who are looking to adopt a child in Ontario either through a children's aid society or through a private adoption agency. We are working with the Adoption Council of Ontario and with our children's aid societies to provide a province-wide Web-based system to bring together children who are available for adoption with families who want to adopt.

To provide appropriate protection and supports for our children, there will be post-adoption support so that families who adopt a child from a children's aid society aren't left on their own, if they are indeed in need of support. We know that we can improve children's prospects for a healthy, productive and overall successful adulthood by providing them with a loving, stable home in their childhood. But in order for these changes to work, we need to also make some changes to the way our 53 children's aid societies work.

Since 1997, government funding to children's aid societies has increased by 168%. While we have recently announced significant funding to assist societies with the pressures they are currently facing, we have also introduced a new funding model that places a greater emphasis on the specific results we want to see for children, like more adoptions. We want the societies to be better able to match their level of response to the individual needs of the child.

Through Bill 210 and the regulations that would follow, we are also committed to strengthening the client complaint mechanism. Our children's aid societies must be more accountable to the children they serve and to the community.

Another legislative change under Bill 210, if passed, should result in the use of collaborative solutions to resolve child protection matters rather than having to resort to lengthy court proceedings. A number of provinces and states already look beyond the courtroom to settle certain child protection disputes. They use mediation, family conferences and talking circles. Evaluations of these methods consistently show positive results, including more timely resolutions, higher rates of settlements, more

satisfied families and better communication between the parties involved—all of this with the interest of the child being the priority. I think it is safe to say that these are all outcomes that we would all like to see for the children and youth in our child protection system.

Together, these changes will help children's aid societies place more children in an adoptive or otherwise permanent home so they can grow up with the security of a family that will be there for them in the long run.

The proposed legislation, along with the other changes that we are making, is driven by a commitment to all of the children and youth in our child protection system.

I would like to take this opportunity to welcome everyone who will come before this committee. By doing so, they are demonstrating the significance of the responsibility that we share for the protection and well-being of these children and youth.

The Chair: Thank you, Minister Chambers. There is now 15 minutes—seven and half minutes for each party—to make some comments. I will start with Madam Munro, please.

Mrs. Julia Munro (York North): Welcome, Minister, to the hearings. Certainly, this bill represents, for the government, obviously, an important step in a process. I think that everyone here recognizes the importance of providing appropriately for children. All of us have the experience in our own communities of situations where children are in great need, and we are always looking for ways by which we can make those kinds of opportunities for our children. I'm very conscious of the expanded definition in 2000 to include neglect, because, historically, this was something that certainly hampered many, many child care protection efforts. I think that it's always an unfolding story, looking for what are the best opportunities, and then to provide greater security and, frankly, a better future for children.

1620

There are many changes, as you have outlined, in this bill. Certainly, at first glance, I think that most people regard these as very positive changes, ones that will give hope to children in the province and that are certainly designed to put children's interests first.

As I said in my opening remarks during second reading of this bill, I think it's very, very important to hear from the experts, as we are here today, particularly those people who have professional experience through the society, through social workers, but also, I think, people who have experienced adoption and who themselves have been through a foster care program. I think all of us are very sensitive to the kinds of statistics when you talk about the average length of time that a child is in one home as being 22 months. So I think that it's extremely important for us to hear in these hearings—and I'm very glad that we've been able to extend the hearing process, in fact, to four days—from that variety.

I'll just comment on a couple of areas in this particular piece of legislation that I think we need to particularly hear some response to, because there are some significant changes. One is the increase of reliance on kinship and

community care, which I think is certainly a positive goal. We know that in many cases, if a father or mother is unable to care for a child, the fact that a child could then go to a grandparent or an aunt or a cousin may certainly be the best one to involve. If we have a parent who has a drug addiction, giving custody to a family member may obviously allow that child to experience the least possible upheaval. Reliance on the courts may also be reduced if we're looking at a system where the child is going to be put within the family. I think that we all recognize the role of extended families, which play a part in the raising of every child, and so it seems to me that it only makes sense that we turn to them first in the case of need. But obviously, the question of kinship care must be guarded very carefully, because many abusive and neglectful parents, in fact, come from families in which these traits have been carried from one generation to another. What we need to hear about and be comforted by, then, are the kinds of safeguards that would ensure that those kinds of processes will take place.

The other area, of course, is the whole question of introducing the notion of alternative dispute resolution. I recognize this as, if you like, the signature part of this piece of legislation. You have referenced the increase in funding in this particular area. Certainly, we know that court time is very expensive for all parties concerned, and so we have to be assured that dispute resolution is in fact going to mean that it is more efficient and certainly less time-consuming than going to court. If it's seen as a precursor to going to court, then obviously it may not be quite as successful as we would want.

The other area that I think we'll probably hear something about is the question of openness agreements. You yourself have pointed out that you're looking to this particular piece of legislation as something that will encourage adoption. Certainly, when you look at the statistic that there are 9,000 children and only 900 adoptions, it's a very startling figure to be given, so we need to be sure that the process by which any openness agreement can be done is one that in fact is going to encourage adoptions. We're all aware that there are avenues in this province and in this country for people to choose alternative routes to adoption, so in one sense there's sort of a competition for those adoptive homes. The last thing we would want is to have it seen as a way that might impede, as opposed to encourage and increase, the adoptions.

I look forward to the public hearings we are about to embark on and will look at them for the kind of support that I know you're looking for in the bill, and the kind of support we would want to provide that makes it better for vulnerable children in Ontario. That's why we're here.

Mr. Howard Hampton (Kenora-Rainy River): I want to raise some issues. Minister, all members of the committee have received a number of letters from First Nations. The letters from the First Nations raise some fundamental issues. I want to read a couple of the letters, because I think this needs to be on the record.

This is a letter from the Lac Des Mille Lacs First Nation to the committee clerk:

"Bill 210 Amendments to the Child and Family Services Act (CFSA)

"Along with other First Nations in Ontario, we are fundamentally opposed to certain provisions of Bill 210 that undermine First Nation child care practice and jurisdiction. We are also concerned about the current legislative process.

"The opposition of First Nations was recorded in resolutions 05/22 and 05/27 passed at the All Ontario Chiefs Conference (AOCC) of June of 2005. Since that time, the Chiefs Committee on Child Welfare, the Chiefs of Ontario Social Services Coordination Unit, and the Association of Native Child and Family Services have reviewed the bill and have confirmed that there are fundamental problems for First Nations.

"In particular, section 44, part 223 of the bill gives the government an open-ended regulatory power to redefine First Nation customary care. That is inconsistent with First Nation child" care "practice and jurisdiction. It is also inconsistent with the spirit and letter of Part X of the" existing act, "which First Nations generally support.

"As the bill affects First Nation rights and interests, the government of Ontario is under a legal obligation to consult First Nations and attempt to accommodate those rights and interests. This legal duty flows, in part, from section 35 of the Constitution Act, 1982. Further, section 2.2 of the 1965 welfare agreement, to which Ontario is a signatory, requires First Nation consent before any significant alteration to a welfare program, including child welfare. The effect of section 2.2 was confirmed by the courts in the Mushkegowuk decision dealing with Ontario Works.

"The provincial government has not lived up to its legal duty to work with First Nations on key provisions of Bill 210. The consultation record on the bill is practically non-existent. This may lead to a judicial finding later on that the bill, if passed into law, is invalid, at least as it applies to First Nations.

"The consultation problem with Bill 210 has been made worse by the committee hearing schedule. Only two days of hearings have been scheduled next week, December 5-6. This does not give First Nations enough time to prepare presentations. To make matters worse, most First Nation leaders will be in Ottawa all of that week attending an important Assembly of First Nations conference dealing with the implications of the recent first ministers' meeting...."

1630

It seems to me that there are lots of objections here from First Nations. I want to ask the question: What has been done by your ministry officials to address this long list of objections?

Hon. Mrs. Chambers: First of all, before you arrived at this committee meeting today, it was recognized that committee hearings have in fact been extended to December 12 and 13 to accommodate that very issue raised by First Nations chiefs who are not available this week. I'm very pleased that they will be here before the committee next week. Next week, while they're in

Toronto, they will also have another meeting with me. Some of them have already met with me, and I will continue to meet with them as much as it takes.

After a very lengthy meeting and consultation with First Nations chiefs and their operational staff, I suggested, and they agreed to, a working group on customary care. This is intended to address the concerns that you made reference to in that letter. Again, we recognize that it is absolutely critical that they be given the opportunity to participate fully in the proposed Bill 210.

Mr. Hampton: May I ask why, when the chiefs have been raising these objections for some time—they raised them over a year ago in 2004, they recited them again in the spring of 2005 and they recite them again in letters that were received just last week—do they have to raise these objections over and over again?

Hon. Mrs. Chambers: I can speak to the term of my being minister. I have never ignored the First Nations community. I have been working with First Nations communities in this ministry from when I was appointed to this ministry and in my previous ministry. You will also hear that I have a very constructive and consultative relationship with the First Nations community. It's something that I'm personally committed to, and I certainly recognize the need to do this.

I have even met with the new grand chief who has replaced former Grand Chief Charles Fox. The new person is Angus Toulouse. I have met with several groups and individuals. I can also tell you that my ministry is working with First Nations communities to build capacity within their own communities to take care of their own children, because I believe that is the most appropriate solution for them.

The Chair: One minute.

Mr. Hampton: This letter was written on December 2. Many of these other letters were written on December 1 and November 30. So these are very recent complaints from First Nations about the fact that they are not being listened to—

Hon. Mrs. Chambers: Well, Mr. Hampton, I guess it's their word against mine. There's nothing more I can say about that.

Mr. Hampton: The concerns they raise are fairly fundamental. One of the concerns is constitutional. Do you think that merely by extending the hearings by two days a constitutional error is remedied?

Hon. Mrs. Chambers: I think you've heard what you want to hear.

The Chair: That's all of the time allowed. I want to thank the minister for joining us and giving us her thoughts.

TIKINAGAN CHILD AND FAMILY SERVICES

The Chair: We will move on to the next presentation. The first witnesses will be Tikinagan Child and Family Services. They are appearing by video conference.

Thank you for joining us. Please proceed. You have 15 minutes for your presentation.

Mr. Michael Hardy: Good afternoon.

The Chair: Good afternoon.

Mr. Hardy: My name is Michael Hardy. I'm the executive director of Tikinagan Child and Family Services. I'd just like to thank the committee for spending a few moments with us.

Tikinagan Child and Family Services is a children's aid society north of the 50th Parallel in Ontario. It's also defined by the Ministry of Children and Youth Services as north of the 50th. It's 99% remote communities that we serve.

We felt it was necessary to present today because any impact from a legislative or regulation change in our case tends to increase the amount of kids in care and involvement with families. We've also attempted many times to have consultations with the Child Welfare Secretariat and were either refused or there was reluctance to have Tikinagan present their unique issues as related to child and family services and related to being a children's aid society.

I'd like to have a three-part presentation: One is on behalf of the chiefs who are corporate members of Tikinagan; two, we have a chiefs' working group on child welfare that's specifically with Tikinagan Child and Family Services; and of course, number three, on behalf of our agency and the children and families whom we serve in our area.

We ask you to consider the following because it really has an impact on our children and families in the communities we serve.

You'll note in the handout that Tikinagan Child and Family Services is the oldest and largest aboriginal children's aid society in Ontario. Tikinagan was created pursuant to an agreement between the Nishnawbe Aski Nation—we are referred to as NAN—chiefs and the government of Ontario in 1984. It currently is mandated as a children's aid society, which took place in 1987.

Tikinagan provides comprehensive child protection services to a large geographic area north of the 50th Parallel, which includes 30 remote First Nations and several small towns and villages.

Through service agreements with the other local children's aid societies, Tikinagan also provides services to its First Nation members in the townships of Sioux Lookout and Red Lake.

As members of NAN, we support our political leadership's position that this bill should not proceed in the absence of full First Nation consultation. The right to care for our own children in accordance with our culture and traditions is an important part of our inherent right to self-government, which is recognized in section 35 of the Constitution.

The Child and Family Services Act recognizes this in its special provisions for First Nations, and part X recognizes our right to care for our children in accordance with our customs.

The constitutional duty of government to consult with First Nations when its actions impact on our rights has

been judicially recognized as recently as November 24, 2005, in the Mikişew case. Consequently, we are disturbed that Ontario proposes to amend the Child and Family Services Act without First Nation consultation.

At Tikinagan, we have a chiefs' working group which assists us in our work. They are upset at the failure of the Ministry of Children and Youth Services to consult them. In fact, they are considering legal action for breach of their right of consultation,

The government's process of dealing with Bill 210 is flawed. It is unfortunate that the government continues to exclude us and, as First Nations, we are forced into a legal and political confrontation with the Ministry of Children and Youth Services in order to protect kids in accordance with the mandates we have been given by our chiefs.

As an aboriginal child welfare service provider, we are concerned about the impact of certain proposed amendments on our work. Since 1987, we've been developing our service delivery model. We call it Mamow Obiki-ahwahsoowin. In Ojibway or Oji-Cree, Mamow Obiki-ahwahsoowin means "Everybody working together to raise our children." It's a system of protecting and caring for children and supporting families that has been designed and is delivered by First Nations people. It is rooted in customary care as recognized in part X of the Child and Family Services Act.

1640

First Nation child care customs are based on the spiritual belief that children are gifts from the Creator and that all are responsible for their care. Customary care is the traditional native practice of child rearing and care within which all members of the family, extended family, relatives and communities are involved in caring for children whose families are having difficulty. Customary care practices are influenced and determined by the culture of the parents and community in which the child is raised.

Within the Mamow Obiki-ahwahsoowin service model, the protection of children is a total community responsibility. Everyone in the community has a role to play in ensuring the protection and well-being of children. Tikinagan has a responsibility to become involved when the family and the community systems are unable to protect a child.

We respect traditional customary practices of caring for children, and we strive to uphold these traditions in the way that we deliver welfare services. Customary care embraces the inherent jurisdiction of First Nations to make decisions for children in need of protection. Through customary care, we work to preserve family unity and build a network of shared community responsibility for raising children.

Customary care is based on Native principles of consensus and voluntary participation, co-operation and collaboration for the care of our most precious resource: our children. The First Nations participate by helping to resolve child protection issues. In carrying out its child protection mandate, Tikinagan works with the First

Nation and community resources to see that the child is protected within the family and the community. Tikinagan's customary care system recognizes First Nations as partners in protecting and caring for children and promoting the well-being of children and families.

Within the customary care system, the First Nation chief and council have the authority to declare children to be placed in Tikinagan care when removal from their home is required. The First Nation, parents, customary caregivers and children in care sign customary agreements for children in Tikinagan care.

Mamow Obiki-ahwahsoowin is designed to respect the inherent authority of First Nations to care for their own children. Our ultimate goal is the pursuit of complete First Nation jurisdiction over our own child welfare services. Until this goal is achieved, Mamow Obiki-ahwahsoowin is designed to ensure that all Tikinagan services eventually meet provincial legislative requirements and are compliant with ministry standards and regulations. Our quality assurance program ensures ongoing compliance.

Our service model promotes the delivery of services at the community level by community-based workers. Tikinagan hires and trains local First Nation members to be front-line workers. We've also developed our own people to be supervisors and senior managers within the agency. In all aspects of service delivery, workers are expected to consult with elders for their wisdom, guidance, teaching and direction. Because of our accountability to First Nations, Tikinagan workers are required to consult with the First Nations on all cases.

Part X of the Child and Family Services Act allows First Nations to develop customary care systems that are parallel to the mainstream child protection system. Since it was first established, Tikinagan has used customary care agreements to place kids in care with relatives for protection where the parties have been in agreement. Customary care enables the agency to strengthen the ability of communities to help families and children.

Bill 210 proposes to empower the Lieutenant Governor in Council to make regulations prescribing standards and practices for customary care. This alarms us because such regulations could jeopardize our years of work and our entire service delivery model. If Bill 210 is passed, we need to ensure that our right to consultation is fully and thoroughly implemented so that government cannot pass regulations that could prohibit our entire way of delivering services.

We are similarly disturbed that there is a regulation-making power with respect to the alternative dispute resolution proposed for part X. We have pioneered a process of alternative dispute resolution by working with Nishnawbe-Aski Legal Services Corp. to develop a program called Talking Together.

Talking Together is an innovative kind of dispute resolution practised as an alternative to the family court system and is based on traditional circles held in the communities. It is conducted in the form of a circle where the child, family members, service providers, com-

munity members and Talking Together facilitators meet. The rules of the traditional circle apply. Everyone is equal. Everyone is given a chance to speak and be listened to respectfully. Comments are framed in a non-judgmental way. The aim of the circle is to arrive, by consensus, at an effective plan to bring about resolution of outstanding child welfare concerns. Talking Together is a process that starts with a referral, moves to a circle, develops planning, and involves monitoring and evaluation. Any regulation passed under the proposed section 45 of Bill 210 could restrict or interfere with our model. Again, we have no assurance that Tikinagan will be consulted in the regulation-making process.

We hoped that this bill would be deferred to allow for the consultation process, which we favour, to take place. If regulations are drafted that accommodate our concerns, then our fears will be allayed. We are willing to work with the Ministry of Children and Youth Services on these crucial issues, but we need time and resources to do so.

Thank you. I trust the committee will give serious consideration to our submission.

The Chair: We will.

Sir, can you please repeat your name? We need your name for the record.

Mr. Hardy: My name is Michael Hardy.

The Chair: Thank you, Mr. Hardy. There are three minutes left, one minute for each party. I'll start with you, Mrs. Munro, please.

Mrs. Munro: Thank you very much for making yourself available for this. You were talking about the fact that if there was an understanding with the government in terms of the regulatory framework that would come from this bill, you would then, through that process, be more likely to be able to support this. I wondered—we don't have much time—if you would just comment on the precise things that you're looking for in the bill to be able to support it.

Mr. Hardy: Being a three-part presentation, first of all, I have to agree with the chiefs in regard to the fact that the First Nations consultation process has to be looked at. However, I've been to such committee meetings before, and when legislation was passed, some of our voices or recommendations were not heard and we ended up with the situation we're in.

If the regulations are going to be developed, we want to ensure that the Tikinagan model that we've currently put in place that is compliant with legislation, compliant with the regulations and standards, is not overlooked, upset and overturned under a new direction. We've worked many years on this.

Mrs. Munro: Thank you very much.

The Chair: Mr. Hampton.

Mr. Hampton: Michael, I just want to go back to the first point that you made. I want to make sure I heard this right. I believe you said, "This bill should not proceed without full consultation with First Nations."

Mr. Hardy: That is correct.

Mr. Hampton: Thanks very much.

The Chair: Mrs. Jeffrey, please.

Mrs. Linda Jeffrey (Brampton Centre): Mr. Hardy, thank you for your deputation. I had one question. I understand that Tikinagan has one of the best practices for customary care and that you're one of the leaders in providing that type of care. I wondered, are you part of the working group that the minister set up on customary care?

Mr. Hardy: Tikinagan is not a member of the native association of family services that was referred to earlier. We're not a member of that, so we are somewhat alone. Because of the Child Welfare Secretariat and the transformation agenda, we were asked to participate on the committee looking at customary care because it seemed to be going through anyway, and if we weren't there, our voice possibly wouldn't be heard. Yes, we're participating.

The Chair: That is all the time we have. Thank you for your presentation.

Mr. Hardy: Thank you very much for listening.

1650

CHILDREN'S AID SOCIETY OF TORONTO

The Chair: The next presentation is from the Children's Aid Society of Toronto: Carolyn Buck. Would you please have a seat? There is 15 minutes total for the presentation and potential questions. You can start any time you're ready.

Mrs. Jeffrey: Mr. Chair, the last delegation indicated that they had a handout. Are we going to get that handout?

The Chair: There is a handout here. I don't have any for the—

Mrs. Jeffrey: Can we get it either at tomorrow's meeting or later on?

The Chair: We don't have them here, but we'll find them and we'll give them to you.

Mrs. Jeffrey: Great. Thank you.

The Chair: You can start any time you're ready, Madam, please.

Ms. Carolyn Buck: Good afternoon. I should introduce myself, Carolyn Buck, and my colleague Cathy Breton, who works with the Children's Aid Society of Toronto as a director of foster care and adoption, which also includes the kinship care program. Our agency is going to make a brief presentation and only touch on three areas of Bill 210: adoption, we're going to speak briefly about kinship and very briefly about the alternate dispute resolution that's proposed.

We'd like to thank the committee for allowing us this time to speak to Bill 210. The Child and Family Services Act, of course, governs our day-to-day work and is therefore vitally important, especially as it provides for or eliminates options for action that affect outcomes for children and youth. From the time of the announcement of the formation of the Child Welfare Secretariat, which was charged with leading this reform and therefore

drafting this bill, our agency has been enthusiastically supportive of the new directions being contemplated.

I should mention to you that our agency in Toronto serves over 33,000 children a year. Given that our agency alone provides daily care for about 1,000 crown wards, we are optimistic that Bill 210 will promote permanency options which have been heretofore unavailable for the vast majority of those children and youth. This has been in large measure due to approximately 75% of crown wardship orders being accompanied by an access order. Current adoption legislation prohibits crown wards with access orders being placed for adoption. Simply put, this group of children and youth have had the option for adoption eliminated from their future. Bill 210 will create much greater opportunity for those children and youth and will move us legally toward what most of society has already accepted through the formation of blended or re-constituted families, shared parenting and joint custody.

Our experience in the adoption department is that many adoptive parents are interested in being able to provide information about and sometimes contact with their adopted children's birth parents when they see that it is important for the child. Currently, the agency grapples with how to facilitate such information-sharing or contact after adoption without creating a legal problem for the parties. Legislation that creates a structure for openness orders or agreements will make it easier to do what is best for those children and adoptive families who want both a degree of openness and some legal certainty.

Our agency is also very encouraged by directions in Bill 210 pertaining to the priority and pre-eminence of extended family in a child's life. While birth families may not be able to adequately provide for their child, we know that many members of the extended family are able and willing to do so. Placing an emphasis on the breadth of family is a demonstration that the child's needs are the first priority, eclipsing other variables such as parents' withholding of consent to disclose information or refusal to ask for help from extended family. We applaud the safeguards outlined with respect to full assessments of kin families, including access to previous history. We believe that this should occur prior to placement and know that this requirement is sound best practice.

Our own kinship program, implemented in 2004, has taught us the precious value of extended families and how supportive and engaged they can become in the lives of their relative children and youth. We have placed about 100 children who have been in our care through our kinship program and believe they have enjoyed greater security, greater stability and predictability than they may have experienced in a foster care system.

In addition, the availability of a custody order under the Child and Family Services Act will streamline practice and empower families. Currently, the least intrusive way to give a child legal status in the care of extended family is through a supervision order, which must be reviewed at least annually by the court unless the family makes a custody application under another statute and commences a second legal proceeding against the birth

parent. The status quo does not encourage families to seek custody. Under the amendments to Bill 210, a custody order will be available right in the CFSA proceeding in appropriate cases.

We are also very heartened to see that Bill 210, if passed, will promote the use of alternate dispute resolution mechanisms for problem resolution. Our own agency has approached many situations, including client complaint resolution, through employing such strategies. This is likely to be less adversarial for all parties and more likely to result in better outcomes for children much sooner than we experience through litigation processes that are often protracted for several years through the courts.

Finally, and in the interest of time, we would like to thank the government for reviewing the Child and Family Services Act and for listening to our field as we carry out our mandate to protect children. Legislation is critical not only to what the work is but also how the work is carried out. This bill demonstrates that you have heard many issues identified by professionals in this field, as well as those identified by our clients who have received service. We look forward to carrying out our work with newer, outcome-based tools, advanced and researched methodologies, and tried and true practice principles. Thank you.

The Chair: Thank you, Ms. Buck. That's all of the presentation?

Ms. Buck: That's it.

The Chair: We have about six minutes, two minutes for each party. Mr. Hampton, two minutes, please.

Mr. Hampton: Thank you for your submission. I'm struck by the different perceptions of this legislation. It's apparent the government has some obstacles with respect to First Nations child and family service agencies. The government may have created those obstacles for itself. As a professional in the field, do you have a sense of how that could be rectified?

Ms. Buck: There's a native child and family services organization in Toronto, and I would think it would be better suited to answer the question. However, I think they have said they would—from what I've heard anyway—like to have a full consultation process, and I can't imagine that that would hurt.

The Chair: Mrs. Jeffrey.

Mrs. Jeffrey: Thank you for coming today. I understand you've been involved in the consultations and you've been active in giving your feedback. I had two questions. The first one was with regard to a staff training perspective. Was there any concern by the society as to how some of the reforms would affect your ability to carry out the work you do from a staff training perspective? The other question was with regard to the client complaint mechanism. There's some desire by the minister to make this system better. Do you have any suggestions on how we could do that?

Ms. Buck: I'll certainly try to answer your question. As far as training goes, with adoption having become, over time, less and less frequent, there are fewer workers, for example, who know how to do proper adoption pro-

cesses, home studies and so on, although we've been very fortunate in our agency because we have a fairly large number of children, relatively speaking, placed for adoption. But I know that in some of the smaller agencies across Ontario, and I expect perhaps the Ontario association could speak to this better tomorrow, they have lost some of the expertise around adoption. It may be that training in that particular area would be helpful.

1700

As far as other training regimens go, it would depend on the kind of safety assessments and risk assessment tools that are going to be promoted or actually implemented. All of the staff across Ontario, if they're new, I think, will need to have some refreshers and learn some new techniques and some of the newer methodology, particularly related to domestic violence and some of the tools that may get employed with that, as it's a relatively new area for our field.

As far as your other question goes, I'm blanking on what your question was.

Mrs. Jeffrey: It was to do with complaint mechanisms.

Ms. Buck: I'm sorry, yes, the complaint mechanism.

We have at our own agency tried several different methodologies to adequately engage clients in a problem resolution kind of process when they have complaints about various things that they feel have negatively affected their service. We've become fairly adept, I think, in many ways at trying to do that, and have employed alternate dispute resolution training for the people who would normally hear those kinds of complaints, and a process whereby people are engaged in—they can bring people with them, advocates or lawyers, whatever, to talk about what their issues are and what it is they feel will resolve their complaints.

One of the things that I think we could perhaps do slightly better is think about involvement of someone from the external professional world, or maybe other systems, to also be a part of that kind of resolution. We haven't done that, but we are contemplating it for the objectivity that that would lend to that kind of process.

The Chair: Mrs. Munro, please.

Mrs. Munro: Thank you for coming here today. I wanted to ask you a question that sort of steps back a bit from the legislation, but I think you'll understand where I'm going. I wanted to ask you about the current situation with regard to children who are in foster care who are then part of that court-ordered process. I think it's important to kind of understand what the purpose of that is and then how that will shift in the new relationship, the potential, through the openness agreements. Could you give us a little background on the current purpose and how you see that changing in the context of an adoption?

Ms. Buck: I'd like to defer this question to my colleague, who does this every day.

Ms. Cathy Breton: I think what we've seen is that social workers and judges are equally loath to sever ties between children and their birth parents. Even though the parent isn't capable of looking after that child, there's a

connection. As a result, some children are made crown wards with access orders and are then in a position where they're in a system that is believed to be permanent—permanent foster care—but which we have recognized increasingly over the years is not permanent for those children. Openness orders or arrangements would allow for those children to be placed with permanent families and still have some connection to their birth families. What we hear from adoptive families, once they have children placed with them, is that they recognize the importance of that for the children.

The Chair: Thank you for your presentation.

CHILDREN IN LIMBO TASK FORCE OF THE SPARROW LAKE ALLIANCE

The Chair: We'll move to the next presentation, the Children in Limbo Task Force of the Sparrow Lake Alliance: Dr. Gail Aitken. Good afternoon.

Dr. Gail Aitken: Good afternoon.

The Chair: Please start any time you're ready.

Dr. Aitken: It's a pleasure to be here. Members of the provincial Legislature, staff of the secretariat, ladies and gentlemen, we appreciate this opportunity for the Children in Limbo Task Force of the Sparrow Lake Alliance to appear before you.

First, I'd like to say that, in general terms, we heartily endorse Bill 210 and commend the secretariat staff for their leadership in putting forward some very important improvements in the CFSA and related legislation.

You have in your folders—I assume you all have those folders—a summary of comments, including 14 points that the Children in Limbo Task Force stresses as needed improvements in our child welfare services. They're not all precisely explicit or pertaining to Bill 210, but we want the legislation to guide us toward achieving these objectives.

You also have—and I won't bother going into this—a sheet describing what the Sparrow Lake Alliance and Children in Limbo Task Force are. You also have a sheet compiled with data from the Ontario Association of Children's Aid Societies, and the most recent data I could get from the Ministry of Children and Youth Services, which is a little less forthcoming, pertaining to the kids in care.

You also have an article in your folders, which has just been released, and it's the article that we on the Children in Limbo Task Force have put forward after research with seven focus groups around the province in different-sized agencies. The focus groups were with youth in care. They were all teenagers, not younger children. We learned so much from them. Some of those comments that they made are in the article. I hope at some point you'll be able to have an opportunity to read that article. There are some very moving comments.

The Children in Limbo Task Force heartily endorses Bill 210, as I've said, but it is particularly gratifying to see a couple of the points we've been really stressing for 10 or 15 years or longer. Access orders should not

present a barrier to adoption. This has had a very negative effect through many years, and it's high time that that was removed. This is the 21st century. There are all sorts of means and ways people have of getting access to information about people. It's about time we modernized this legislation.

The other thing that some of us have been harping on for a long time is the need to provide alternatives to classical adoption and to give more flexibility in terms of what can be done to provide permanent placements for these young people in care. Unlike some provinces, we've been a little slower off the mark on some of these options. We want the flexibility and we want the custody arrangements—in some jurisdictions, I believe “designated guardianship” is the term that has been used. These are important measures to provide permanency for young people who really have been bounced miserably from foster home or group home to other locations and have had no security in relationships with workers as well.

So the moves to develop other forms of kinship care and customary care are especially important. I mention customary care because we are aware, and we hear, even living in this part of the province, that some of the children in worse circumstances are from the native communities, the aboriginal communities. So whatever can be done to facilitate appropriate measures in terms of customary care should be done. It's absolutely essential.

We would caution—I will go into the chief points we raise from the paper—that the implementation of Bill 210 is important, but there must be clear and specific regulations to really ensure that the bill can be implemented, and there must be resources. Without that, we are failing our children.

1710

Now I'd like to just review briefly some of the 14 points that are listed in your folders on these sheets. I'll perhaps go through those rather quickly.

Prevent children from coming into care in the first place. There's inconsistency in the level of family support that is available throughout the province.

Provide extensive family group conferencing to mediate family breakup when children must come into care. As we had brought out very clearly at a forum that we had on Friday afternoon where there were a great many young people, about 15 among the 65 or so of us who were present, emphasize that we need to pay attention to remaining members of the family, particularly siblings, when children are brought into care.

We need to improve continuity of care and contact, much greater stability in placements and continuity in worker caseloads. You can see the data sheet that's in your folders there. You can peruse that later.

We need to promote more open information-sharing with children and youth in care and, whenever possible, ensure their participation in decisions about their lives. This a common complaint. When we listened to all these youths' voices in the seven focus groups that we held around this province with various CASs, this is really the clear demand: “Listen to us. The children want to be heard.”

We also know that the Family Court must be made more child friendly. Some of the youths told us of awesome experiences in going to court. Surely we can do something to make that whole process more humane for those who do end up in court. It's not necessary that all children being brought into permanent wardship go to court.

Reduce the stigmatizing language used in child welfare: ceasing to use the word "apprehension," for example. Instead, talk of "bringing the child into care." As it is, children are confused between criminal court and Family Court. We need to consider the language that's threaded through the legislation and regulations employed in the agencies. Use "contact" instead of "access" to distinguish it from post-divorce terminology.

Employ foster parents—perhaps it's an idea—as agency contract staff as a means of providing them with greater training, support and monitoring. They also need essential information if they're going to cope well with the children who are placed in their care. Investing in foster parents is extremely important. They are the best therapeutic resource we have for children coming into care.

Limit the time spent in limbo by streamlining permanency planning with emphasis on finding long-term placements as soon as possible after children come into care. They're very damaged if they don't become crown wards. The average age now is eight and a half. There are 9,100 crown wards in this province and around 19,000 children in care. This is not a good picture.

Reduce barriers to adoption, particularly by allowing children with access orders to be adopted. You've already heard about that.

Provide long-term alternatives to adoption—which I've mentioned we feel is one of the most important points—such as designated guardianship or custody/customary care arrangements for children and youth for whom adoption is not appropriate.

Facilitate interagency co-operation and information-sharing. That sometimes, we hear from workers, is a real barrier to doing the best for the child because they're restricted in the kind of information-sharing that goes on from agency to agency—current barriers that stress confidentiality. Interprovincial relationships are something that you people are going to have to consider if out-of-province kinship placements are to be considered. Sometimes Ontario children will have a close relative out of the province who is willing to act as the guardian, but that demands a kind of contractual arrangement, and I think with a lot of the provinces the road to that isn't quite smooth enough to facilitate it yet.

Provide ready access to post-adoption or post-placement services for young people, adopters or guardians of their own volition. Recognize that post-adoption/post-placement services are essential, especially considering the trauma and turmoil that many in the crown ward population have faced. Again, see the enclosed data sheet.

Ensure greater support, both personal and financial, for young people leaving care—how many stories we

hear of 16- and 17-year-olds in desperate circumstances. Permanent wardship should be continued until age 18 and not terminated at 16, as at present. Extended care and maintenance must be increased, as the current level of \$663 per month, plus a Metropass in Toronto, is inadequate for these young people. What would you do with your own families? And consider supporting these young people until they're 24 years of age if they're in ongoing education.

This is a really important factor too: There must be extensive public awareness campaigns to educate the public about changes in the legislation, openness in adoption, alternatives to adoption and the need to remove the stigma now facing children and youth in care. We were absolutely shocked at the tales of stigmatization that the youths in these focus groups presented. We hadn't realized—I hadn't realized, and I've been around a long time—the extent to which these children who are in foster care or group homes are stigmatized at school. It really is very concerning.

This is Dr. Jacqueline Smith, one of the authors of the paper, Gitte Granofsky, and back there is Ryna Langer, who was also one of the authors of the paper that is here in your journal.

Jacqueline, would you like to read the quotation that I have there at the end?

The Chair: There are two minutes left in your presentation.

Dr. Jacqueline Smith: I would just like to quote one statement by one of the youths in the focus group that we conducted, among the many that we would have liked to present to you. This young man, in the middle of the session, turned to his peers and said, at 14, "Should I decide I want to be adopted, I could be on the waiting list forever. Or should I stay in foster care?" He was asking his peers. He would have liked to be adopted a long time ago, but he had one grandmother left that he wanted to be able to visit. He was afraid that if he asked for adoption, his ties to his grandmother would be severed. Clearly, this young man was looking for permanency.

I would just like to end here with a quote from Daniel Hughes, who is a noted psychologist in the field. He says, "All children, at the core of their beings, need to be attached to someone who considers them to be very special and who is committed to providing for their ongoing care. Children who lose their birth parents, especially those who have experienced the trauma of abuse and neglect, desperately need such a relationship to heal and grow."

Our plea to you is to allow permanency to take place for these children, because without permanency and without the opportunity to be attached to someone who cares for them, there isn't the opportunity to recover and to heal from their past experiences.

The Chair: Thank you. We have about a minute for questions. Mrs. Jeffrey, any questions?

Mrs. Jeffrey: I don't have a question. I just wanted to thank you for your heartfelt, constructive advice. I think you've made some really practical suggestions that are very useful. Thank you very much for being here today.

The Chair: Mrs. Munro.

Mrs. Munro: I would just want to echo, certainly, that you've given us lots of food for thought.

The Chair: Mr. Hampton.

Mr. Hampton: I do have a question. If you've been sitting here, you must be struck by the degree to which the government has consulted with non-native agencies and non-native organizations and has not consulted with aboriginal organizations. Do you have a suggestion as to what the government should do to overcome what I think is a very unequal situation?

1720

Ms. Gitte Granofsky: I think that we really don't have enough information about how much consultation has been going on. It's not my impression. We had some native people also from a local child and family service at our meeting on Friday and didn't hear those concerns. It seemed to me that there was some consideration for the native community, but I'm not aware of the legalistic issues involved.

The Chair: Thank you for your presentation.

EKATERINA ETHIER

The Chair: We'll move on to the next presentation from Ekaterina Ethier. Madam, you have 15 minutes in total. If there's any time left, there will be questions asked. You can start any time.

Ms. Ekaterina Ethier: Honourable members of the standing committee on social policy, ladies and gentlemen, I want to dedicate this presentation to two very special people: One is Jeffrey Baldwin, who died in Toronto from starvation at age five, and it's our shame to allow this to happen. The other one is my son David Ethier, who is 10 years old and autistic, and who was forced to move to Europe due to the lack of services for autistic children above age six.

My name is Ekaterina Ethier. I'm a systems integration specialist. I'm a professional engineer in professional practice. I hold two masters degrees and a Ph.D. I specialize in business systems, management, governance, and auditing and compliance, including legal compliance, and I do, in day-to-day practice, take responsibility for your safety. I assure that safety defects in systems are less than eight defects in a million. On the other hand, I'm the mom of an autistic child.

The reason I wanted to talk to you today is the proposed changes in section 68 of the Child and Family Services Act. The current state of the Child and Family Services Act, section 68, is as follows: It is addressing complaints; more specifically, customer complaints. It allows the ministry to capture problems with the director's review process. It allows the minister to remedy the problems with recommendations, directives and even management takeover under section 22 of the Child and Family Services Act. In addition to that, in subsection 68(1), there is a self-created CAS complaint process that creates a double standard within the province and prevents the public from complaining to the ministry.

The most important processes that regulate a business system are a customer complaint process, a corrective action process, a preventive action process, and audits as a natural flow out of the complaints.

The CAS self-made complaint processes: Currently, some complaints with the CAS are verbal to prevent the opportunity for audits. Complaints are not tracked and captured in any way. No corrective actions are taken upon complaints. The attitude is usually that the CAS worker is always right. Those complaint processes are deliberately preventing the public from complaining.

The ministry director's review process is poorly defined with a general guideline, opens opportunities for a double standard, and does not comply with privacy laws. It doesn't work, because of the ministry's maladministration. The legislature currently is making decisions based on false statistical data provided by the CAS. There is no process to assure the accuracy of information.

The proposed changes to section 68, and more specifically the removal of the director's review process, will prevent the ministry from capturing the problems. This will increase the severity of maladministration in the child protection system and will prevent the children in care from seeking a remedy. This will negatively affect the children with disabilities and their families seeking special services agreements. This will cripple the Child and Family Services Act and make it more dysfunctional. It is the legislators' duty to protect the public and prevent opportunities for maladministration.

What needs to be done to protect the public? Make the CAS complaint process an opportunity but not a requirement. Keep the complaint in front of the board of directors an opportunity, but well define that this is not a requirement. Redefine the director's review process as a core process to capture problems within the system and trigger mandatory case process audits followed by corrective and preventive actions. This will have the positive effect of increasing the efficiency of the child protection system. The minister might say, "Too many complaints." Then there is something wrong with the system, and it has to be fixed.

This is a picture of my son and myself before he left Canada in 2004. He now lives in Europe. We tried to complain to a number of government agencies. I even tried to make an appointment with Ms. Julia Munro. We faced a brick wall. I started my complaint process in 2003. I'm currently in the director's review process stage. It took me two years to get to the director's review. The only thing I wanted was simply to have a case process audit, because the information in my file is falsified. What happens currently is that the director, in my opinion, is not familiar with the provincial standards, and specifically, eligibility for services and risk assessment. The only thing I wanted was my case file to be matched against the provincial standard.

I wish to thank you for your time.

The Chair: We have about four minutes left. I will start with the opposition. Mr. Arnott and Ms. Munro, one minute, please.

Mr. Arnott: I want to thank you very much for your presentation this afternoon. I think your input is going to be very helpful to this committee as we continue our deliberations on this important piece of legislation, so thank you very much for your input.

Ms. Ethier: You're welcome.

The Chair: Mr. Hampton.

Mr. Hampton: I wanted to ask you about the autism issue. Where's your son now?

Ms. Ethier: My son is in Bulgaria since 2004. I'm flying on Wednesday to spend Christmas with him. Otherwise, I work here in Ontario. My husband is working for a major financial institution. He's a CISSP as well.

The Chair: Thank you very much. I'll move on to Mrs. Jeffrey. One minute, please.

Mrs. Jeffrey: Thank you very much for coming. Clearly, you have concerns with the accountability of children's aid societies because you think it takes too long. I guess my question would be, or my comments are, these are helpful suggestions, because I believe some amendments will be forthcoming. Do you have any other suggestions? You've said it takes too long and that you're not taken seriously—your complaints.

Ms. Ethier: Well, I have another suggestion. For example, in York, I requested the service of a worker who has English as a second language. There are 200 workers; I was told that none of them have English as a second language. Simply, the cultural issues, the issues of diversity are not considered, and sometimes especially new immigrants are simply the subject of genocide.

The Chair: Thank you, Madame Ethier, for your presentation.

1730

ADOPTION COUNCIL OF ONTARIO

The Chair: We'll move on to the next presentation, from the Adoption Council of Ontario: Patricia Fenton. Please have a seat, Madam. You have 15 minutes for your presentation. You can start any time.

Ms. Patricia Fenton: Thank you, Mr. Chairman, ladies and gentlemen of the committee and guests. Thank you for giving the Adoption Council of Ontario an opportunity to respond to Bill 210. I first of all want to say that we are very much in support of the bill, and want to address just a few of the components of the bill.

Let me just say a little bit about myself. I am the executive director of the Adoption Council of Ontario. I'm also an approved adoption practitioner and an adoptive parent in an open adoption. The adoption council is a non-profit, charitable organization. I think you have in front of you a brochure which describes a number of the things that we are and what we stand for. If I could just briefly summarize, this is an organization that started in 1987. Our membership and the board of directors are made up of representatives of the adoption community, including adoptees, birth parents, adoptive parents,

professionals and also some of the agencies. We have over 400 members at present.

As an umbrella organization within the adoption community, we advocate for adopted persons and all people connected with adoption. Our activities basically focus in four areas: adoption information, adoption education, support and advocacy. Our mission is to provide support to individuals, families, groups and organizations in Ontario that are concerned with adoption.

We strongly believe and embrace the concept that all children deserve a forever or permanent family. We believe that every child in Ontario deserves a loving, permanent family. Early planning in this regard is a key to ensuring a promising future for the child.

We support the bill in its attempt to address the fact that permanency can take many forms, including efforts to keep the child within their birth family and extended family in kinship care, guardianship and adoption, and that access orders should not prevent children—crown wards in this case—from moving into adoption or other forms of permanency.

This legislation will lift the existing barriers for children and clear the way for the permanency planning that can allow for more flexibility and greater options. We welcome the efforts to address the confusing and cumbersome system of adoption in Ontario. We hear from applicants at our centre about how confusing or how difficult or—how to figure out this system is what they're trying to do. Many of them become very frustrated in waiting for services, waiting to get calls back. Some of the frustration leads them to consider international adoption, and while we have no objection to international adoption, we feel we're losing some very good families who could be matched with children here in Ontario.

The Adoption Council of Ontario, or ACO, supports Bill 210's proposed changes with respect to openness in adoption. Too many children in Ontario are prevented from moving on to adoption because of the access orders. Openness agreements or orders, when in the best interests of the child, contribute in a positive way to healthy development. They give the child the security of an adoptive family while at the same time respecting the importance of those established relationships and connections. I've certainly learned about the importance of that through my own daughter, who from as early an age as four had lots and lots of questions and even concerns about what was happening with her birth family. Particularly, she wanted to know about her birth mother.

The openness that Bill 210 refers to can take many forms, and we see in the private sector already, with open adoption arrangements, that there are many ways that can translate, from exchanging information indirectly all the way through to face-to-face meetings or visits where the child and all members of the adult part of the families, both sides, can have a chance to connect and visit, as well as with other children. Adoptees tell us that these connections to birth family can help them to feel more secure and to develop a stronger sense of their identity, particularly in adolescence.

Further, ACO supports Bill 210's proposed legislative changes that call for increased post-placement support, including parent education and other services.

Parent support is extremely important. We've seen that through our adoption resource centre. Through our work with families there, we've been told repeatedly about the benefit they find in being able to have access to workshops, educational opportunities, support groups, to various ways of connecting with other families who are experiencing similar kinds of parenting issues or questions. Providing this after placement to assist the families is very important. To talk about placing the children and not also talk about the supports that need to be there is only part of what we need to look at. This bill looks at the importance of that.

As a council, we are involved twice a year in the adoption resource exchange and do a one-day conference in connection with that. The focus of that conference has been primarily pre-adoption and helping people understand about the needs of children who are currently awaiting adoptive placement. However, as time has gone on, we've included more workshops that deal with post-placement issues. More recently, at the October conference, we had an adoption-in-the-school-system workshop which was very well attended. We had an overwhelming response from parents who had a variety of questions and concerns about their child's educational experience. That's one example of the kinds of post-placement adoption supports that could be in place.

We recognize that a permanent family can take any one of many forms, both kinship family or guardianship. We support the changes that are proposed. We realize that adoption isn't the answer for everyone. Focusing on early planning is important, ensuring that a permanent plan is put forward in a timely manner. This approach acknowledges that a child may have established meaningful links to significant others and that to sever these links could be detrimental to the child's emotional health. A custom-made, case-by-case or flexible approach to permanency means that a plan for every family may very well be identified within that constellation.

We also support the use of alternative dispute resolution methods as proposed, as we see that this provides an opportunity to move the process out of an adversarial kind of arena and help to avoid the lengthy disputes that may hold the child back from moving into a permanent family as quickly as possible. The proposed act acknowledges that this method of resolution can be utilized at various times throughout the child's life to vary openness orders as needs shift and change.

When it comes to the openness provisions, I think it might have been hinted at earlier that people may be scared off by that notion. In my experience, good education and understanding of the importance of openness from the child's perspective, and also including in that education program the voices of the birth families, can really help adoptive applicants better understand openness and help to remove some of those fears that seem to be in the initial response to that.

In fact, the private sector has been practising openness in adoption for many years. We've shown that that can work and that families, both biological and adoptive, can maintain connections for the benefit of the child. With the appropriate adoption preparation and supports, adoptive parents can quickly adapt a new way of looking at adoption, instead of it cutting off what has been there for the child, embracing those and having that as part of their understanding, but also feeling entitled as parents.

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The adoption council is pleased to have been a lead organization for the Adopt Ontario program, which is an adoption recruitment program. It began as a pilot project under funding from the Ontario Trillium Foundation. It developed as a collaborative model of public and private workers as well as the council and the ministry coming together to help to recruit families for children who are in our foster care system. We're very pleased at the way that this has been working. We have seen the placement of over 50 children through this program. It has shown that the systems can work together, as we have six of the children's aid agencies that are part of the steering committee for this program.

The primary goal of this project is to recruit adoptive families throughout Ontario. These are for special-needs foster children who are eligible for adoption. It's aimed at increasing the number of adoptive placements for special-needs children and visible minorities. This uses an Internet Web site as well as the Today's Child column in the Toronto Star. Through this, we've been able to feature over 93 children, and 50 of those have found permanent homes.

I've given you a little card which has a very basic outline of the program. This certainly is very much in sync with the goals of Bill 210, and we'll be very pleased to work to continue this program in conjunction with the ministry's goals.

The next step of the Adopt Ontario program is to establish a data bank of approved adoptive couples and families who are looking to adopt. The profiles of the families would be placed on the Adopt Ontario Web site. I invite you to visit the Web site: adoptontario.ca. An addition would be to have information about waiting families so that workers can more easily and more readily access that information. Right now, they're reliant on very informal networks as well as the twice-yearly adoption resource exchange, but this could be an ongoing, 24/7 program to offer that. We're in the process of looking at the kinds of information that would be contained in that, whether the home study of the adoptive applicants would be part of that or just what that would look like. We're happy to be in consultation on that whole effort.

In conclusion, I would like to say that we support Bill 210. We urge you to pass it. It's based on research, on best practice, and it seems to us to be the right thing to do for children in need of permanent families.

The Chair: Thank you, Ms. Fenton. There's only a minute left. We'll take 30 seconds each. Mr. Hampton.

Mr. Hampton: No questions.

The Chair: Mrs. Jeffrey.

Mrs. Jeffrey: You're the second delegate this afternoon to talk about post-placement support, so clearly that's an important issue. You spoke a little bit about the workshops and the support groups. Do you have any other specific suggestions that you would make?

Ms. Fenton: I think there's lots that falls under that general heading of post-placement supports. It can be support groups for parents; it can be workshops; it can be a place to call to talk to others who've been through something similar; it can be resources, as in a resource library; it can also mean adoption-competent professional services. All across North America, that's an area that has been lacking. Training in adoption and full understanding of adoption issues is something we really need to do more and have opportunities for professionals to be able to respond to the needs of adoptive families and their children.

The Chair: Ms. Munro.

Mrs. Munro: Just a quick question: When you talked about your experience with existing openness agreements, I just wondered if you have any research that would demonstrate if there's any difference according to the age of the child involved. Is there a trend; is there any kind of best practices? Any comments on that?

Ms. Fenton: I personally don't have any research, but I know that some of the research that's been done so far has really focused on long-term outcomes for infant placements, and it's only recently, and most of this would be in the US, where they're looking at openness in the context of an older child adoption placement.

The Chair: Thank you for your presentation, Ms. Fenton.

LEGAL AID ONTARIO

The Chair: We'll move on to Legal Aid Ontario: Janet Leiper.

Ms. Janet Leiper: My name is Janet Leiper, and with me are George Biggar, vice-president of policy planning and stakeholder relations for Legal Aid Ontario, and David McKillop, who is our director of policy. We're very pleased to be here this afternoon. Thank you for inviting us.

As most people here may know, legal aid's purpose, in the constellation of services in Ontario, is to provide increased access to justice for low-income people across Ontario. Our clients include new Canadians, youth, aboriginals and especially families and children, so we are very interested to be here today to make some brief submissions to you about Bill 210.

In the past six years, since the last significant amendments to the Child and Family Services Act, there has been an increase in public awareness about child abuse and neglect. The awareness has led to a legislative response which, in turn, led to an increased and unprecedented expansion in the number and complexity of matters that are being heard and dealt with by children's

aid societies, courts and parents' counsel. We fund the majority of parents who come before the courts on child protection matters. This has meant that there has been an increase in demand for our services by way of legal aid.

We have also watched a steady increase in the budgets of child protection agencies, which also drives service. Since 1998, their funding has increased to \$1.1 billion, an increase of 100%. During this same time period, our funding as a base matter to deal with increased demands has essentially remained the same. There is a strong correlation, obviously, between increased children's aid society activity, court litigation and the demands on Legal Aid Ontario.

Our certificates are provided to the private bar to represent family matters as well as criminal matters. But on child protection, the demand for our certificates and our costs increased by a staggering 81% from 1999 to date: from \$8.5 million to \$15.4 million. The situation is one that legal aid and the province can no longer afford.

At the same time, we have watched funding fail to keep pace to be put into programs and remedial parenting courses that would allow families to stay together. Our own needs assessment studies done by Legal Aid Ontario have confirmed this lack of services and the "litigate rather than negotiate" attitude that has been adopted in certain areas around the province.

The challenge for us is that families typically affected by increasing children's aid society intervention are those that we'll be called upon to assist. Most of these families live at or below the poverty line. They are led by single parents. They often rely on social assistance. A significant percentage of them are from cultural or racial minority groups. This is the profile of the typical family we see.

This doesn't just affect us. We're not just here on our own behalf. It affects—and we see it—the courts. Significant backlogs have developed in family courts across the province. The backlogs have been exacerbated by the fact that there is a shrinking pool of lawyers who are prepared to accept legal aid certificates to defend these very difficult, heart-wrenching cases.

We wanted to put that by way of pressure before you, and now we want to say some nice things about the bill.

First of all, Legal Aid Ontario is supportive of the direction of this bill. We feel it's a signal of a major shift in thinking in the child protection field. We have also consulted, to bring to you some of what our service providers are saying to us about the bill. Based on our consultations, there are three things we would like to say this afternoon that we particularly like about this bill.

The first one is the increased flexibility in how children's aid societies can use their funding, with the goal of keeping children in their own homes. They will have the authority to use a portion of their funding for episodic responses; for example, having the heat turned back on, where a few hundred dollars might result in a family being able to provide a safe environment for a child. Making it easier to obtain a custody order to have a child

placed with extended family members or friends on a short- or long-term basis: We applaud this as well.

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Of particular interest to Legal Aid Ontario is the introduction of alternate dispute resolution processes in the area of child protection. We believe that by introducing ADR to the child protection field, court proceedings can be shortened or in some cases avoided altogether.

However, in order for this to be successful, we urge that you consider the need for independent legal advice at the very front end so that people have the knowledge and the ability to make the decisions that are best for all of them. We flag this for you because we feel a thoughtful set of regulations will be required in order to make this a reality and to support the move toward ADR. Right now, the way it stands, a legal aid certificate is only available once the children's aid society has brought an application under the act, but by this point in time, it might be too late to improve the outcomes for everyone. If independent legal advice is available pre-apprehension and pre-application, this will assist. So bring us in at the front end. Yes, it may cost some more initially, especially as we look to combining the system; however, this will give informed advice to the permanency issues that should be talked about as quickly as possible. So we do flag that this portion of the bill would require some upfront investment, and an investment from us, that funding from government will be needed to assist, but we think it's of great value to everyone.

Those are three things I wanted to say by way of what we like, and we have one area that we'd like to flag for you by way of, "Could use some improvement." Perhaps you would consider it.

We applaud the introduction of openness orders and agreements to permit continued contact between an adopted child and a birth parent, sibling, relative or any person with whom the child may have a significant relationship. It's our view that birth parents and children's aid societies should have an equal right to apply for an openness order. Currently, the proposed amendments only permit the children's aid society to apply for such an order, and this decision is not reviewable.

The amendments stipulate that if a child is made a crown ward, existing access orders must terminate. The stated reason for this is that children cannot be adopted if birth families have a court-ordered right to visit or contact them, and the amendments are trying to make it easier for crown wards to be adopted. This is admirable, but the sad fact is that 58% of all families never exercise their rights, and thousands of crown wards who are rarely, if ever, contacted by family members live for years in foster or group homes. While the proposed amendments permit a new access order to be made, they raise the threshold for caring and committed families to obtain one. Under the current wording of the Child and Family Services Act, in section 59, "The court shall not make ... an access order with respect to a crown ward ... unless the court is satisfied that" it will "not impair the child's future opportunities for a permanent or stable

placement." Under the proposed amendments, "permanent or stable placement" will be replaced by the word "adoption." This is a more difficult onus to meet. It will be difficult for birth parents to establish the evidence that would allow them to rebut this presumption. So we're here to ask, does the committee really want to leave in place an irrebuttable presumption of this sort?

If the amendments allowed for a more flexible approach to determining access between a child and birth parent after adoption, Legal Aid believes the number of trials seeking crown wardship with no access for the purpose of adoption would be significantly reduced. We do not believe this needs to be changed in order to avoid a chilling effect on adoptions. We would argue and would ask you to adopt a middle ground that would permit the issue to be negotiated amongst all the parties. Our society's concept of family is increasingly fluid. There are a variety of views. Flexibility is better for our clients, and more options are better for our clients.

In conclusion, thank you for allowing us to be here and to express our views. We wish to congratulate the Ministry of Children and Youth Services for its insight and commitment to the children of this province. Thank you for the opportunity to be here.

The Chair: Thank you. There are two minutes, so we'll take one minute each. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I'm not a lawyer, so I'm just wondering, can you reference the sections in the bill that you would like to see amended? You've given a sort of narrative around where the changes should be. Is it section 36 of the bill, 37? Where exactly are you looking for the changes?

Mr. David McKillop: The sections that we were referencing were sections 58 and 59.

Ms. Wynne: All right. That's fine; as long as I know where to look.

The Chair: Mrs. Munro.

Mrs. Munro: Thank you very much for this, because it's very specific in certain areas. I guess my question has to do with the alternative dispute resolution, because when I made my comments at the beginning today, I said that I thought this was good, in theory. My concern is, is it more costly? Is it only a precursor to possible court action? Do you feel comfortable with it the way it's written, or do you see that there need to be some changes that better state what you want coming out of this?

Ms. Leiper: I'm going to ask George Biggar to speak to that.

Mr. George Biggar: Well, there are two things in your question. To answer your second question first, I think we are comfortable with it as it's written. We recognize that there have been important strides made in bringing forward the concepts of ADR in child protection matters and that it's a relatively new concept.

We participated, along with the Ministry of Community and Social Services, in funding a three-year-long project looking into mediation and its success or its benefits in child protection matters. We're satisfied that that report shows it is a technique that offers some

possibilities of improved outcomes for our clients, for the children and for the system as a whole, but it's not the be-all and end-all, and it's not necessarily cost-effective. That's our concern, that in order to make it work, we may need to be providing lawyers earlier in the process, and at the moment, we are not funded to do that.

The Chair: Mr. Hampton.

Mr. Hampton: I want to ask you the same question I've asked others. I'm struck by the degree to which non-native organizations are generally in support of the bill, yet chiefs and aboriginal organizations have raised some fundamental issues. Since Legal Aid Ontario does deal with a number of aboriginal parents and generally with aboriginal populations in the province, do you have any advice on how to resolve this? It seems to me that there's a fundamental unfairness if the government is saying, "Well, non-native agencies, non-native organizations are very much in favour of this, and aboriginal people may have their problems, but we're going ahead." Do you have any suggestions about how to fix this?

Ms. Leiper: In terms of the consultation, I suppose you could open up your process for a bit longer or give people more time to respond. That was one thing that we were confronted with.

I will say, in terms of talking to you about native and non-native, that we're here for both, because we do provide services through the Nishnawbe-Aski Legal Services Corp. in the north. In fact, they've done some really interesting things. I'm running out of time to tell you about it. But the Talking Together program, which is a circle to deal with child protection issues, has been working for the last couple of years with native families in finding alternatives. I heard a presentation by the woman who runs that program. She said, "It's so amazing to hear family members come and say, 'No one ever asked us what we thought before.'" So it shows you that these things are out there, and I think you find a wealth of people wanting to tell you what they think.

We'd be happy to help if we could bring some more people here from other sectors. We certainly have contacts all around and through the north, because we're in all communities. But anyway, whatever we can do to help, we'd be happy to.

The Chair: Thanks very much for your answer. I think we've used all the time.

Ms. Wynne: Just for future reference, I wanted to clarify: It's my understanding that it's sections 16 and 17 of this bill. If there's any other section that you're referencing, could you let us know that? But as I understand it, those are the two sections.

Mr. McKillop: That is correct.

The Chair: Thanks for your presentation.

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OFFICE OF CHILD AND FAMILY SERVICE ADVOCACY, YOUTH GROUP

The Chair: We'll move on to the next presentation, the Office of Child and Family Service Advocacy, youth

group, please. Good evening. Have a seat. There are a number of you and we have instructed the camera what to do. Please keep in mind that there are 15 minutes in total, and we are running out of time, unfortunately, at today's meeting. The total time is 15 minutes. If there is any time left, then there will be some questions or statements. You can start any time you're ready.

Ms. JulieAnn Erbland: I'm just going to introduce. I'm from the advocate's office and so is Patrice. Judy Finlay, the chief advocate for the province of Ontario, was unable to be here today, but she hopes to have an opportunity next week to speak to the committee. She asked that I pass on how important she feels it is for the young people to have an opportunity to speak to Bill 210. At the advocacy office, we feel that it's young people, like the young people who are here today, who bring an expert perspective, because they have lived experience of the issue. Therefore, the advocacy office feels it's critical that you hear what they have to say.

The Chair: Please start.

Ms. Talita Brown: Good evening. My name is Talita Brown, and my reason for standing here is to take part in the decision-making for Bill 210. I am representing myself and my experience as a youth in care. I was taken into care as soon as I was born, because my parents were incarcerated and I had medical problems. My grandmother was willing to take responsibility for my sister and me, but she was not financially stable enough to provide for us. I was placed in the care of a couple that, to my knowledge, had built a loving home and cared for more than 10 children.

I was happy for the first five years of my life. Everything had shattered into broken promises and dreams when an older foster brother accused the foster care parents of physical abuse. He was angry because he wanted to party, hang out and do drugs, but the foster care parents were strict and wouldn't allow him to do what he wanted. He then faked his injuries and the next day filed a complaint of physical abuse against the parents. The house had undergone an investigation, and every child and youth was taken into a room at the front of the house and was asked to strip from head to toe so that a worker could check for physical injuries or any sign of physical abuse. Even though it was clear that no signs of such abuse had taken place, we were removed and placed in another foster home. Those who were 16 or older had been given a choice to stay, and all who were 16 or older stayed.

The second home we were placed in was nothing like what we were used to. We were not allowed into the kitchen and were told when to use the bathroom. I felt no love in this home. One day I had split my head open sneaking into the kitchen to make hot chocolate because I was not allowed to enter the kitchen and get food. I hit my head on the corner of the cabinet. It was not until I saw the blood on my pillow afterwards, from laying my head down because it hurt so bad, that I realized what had happened. I started to cry. My sister overheard me and came rushing to see if someone was hurting me. She

immediately saw the blood on my hands and started to scream for the foster parents. They both came out of the room yelling at us. For 10 minutes they stood yelling at me until my sister stated that I was bleeding and needed medical attention. They took me to the hospital and I was bandaged up, or as they put it, glued together.

Life was rough for my sister and me, and neither of us knew that it would be getting worse. Sometimes we were punished for not following rules and sometimes for no reason at all. She was constantly yelling at us and slapping us around; not hard enough to make a physical bruise but enough to give you a rude awakening. We talked to our worker many times about leaving and how we were being treated, but our new worker had not the slightest interest in what children had to say and believed the foster care parents over us. Our first worker had been changed after we had moved from our first home. She would try to come to see us but would seldom make it. She cared for us and was the second person besides our first foster care parents who did. We spoke to her a lot and felt able to talk to her.

My experience with the court system was that when I was seven, my sister and I would attend a hearing on behalf of my father and mother. I was not aware why I was going or what effect it would have on my life. I wish that I had been told about what was going on. I remember seeing all these new and some familiar faces, and I was confused.

The judge asked me questions that I didn't understand because I had not come to the understanding of the fact that I was in care. I did not know much about my biological parents, and still believed that my first foster care parents were my real parents. The judge had asked me if I wanted to live with them, if I had loved them, if I loved my foster care parents more than them and if I wanted to still see my foster care parents. I did not know what to say, and answered the best that I could: "Yes, yes, I don't know, yes, yes." After that, we returned to the foster home.

It was a couple of months later that we returned to the court and spent time with relatives in a room. I did not know at the time that we were in the process of being placed in the care of relatives. Within weeks, we were placed in a group home for assessment, and then we were placed with aunts and uncles. I really hoped this would be the last move for us. There were so many moves and we were so confused and angry. We didn't know who to trust. When we got to our relatives, we were acting out. I moved so many times in my childhood from relative to relative and felt no one wanted to care for me. I felt lost and invisible to society. I wish I had the CAS looking out for me and for my best interests. Instead, they left me with unfit caregivers and I felt abandoned by everyone, especially the CAS.

I am now 19 years old and working toward my high school diploma. I still carry the emptiness from not having a stable environment. I wish I had a constant guardian to educate, mentor and look out for my best interests.

I am thrilled to hear about positive changes being made and the implications of Bill 210. I believe that with this bill, children and youth are not going to be lost in the system and uncared for the way I have been. With every decision that you decide to make, I am asking that you take into deep consideration what you are going to do with the lives of people who depend on your decision today. Remember how you once made a decision for my life: The effects of that decision forced me down a road that I briefly explained.

What you make as a law to abide by in this country affects all those who live here, including you. It's difficult to put in simple words how this law will affect everyone. My only wish is that you consider how you want your children to be raised if you are in here to look after them. I'm asking you not to just give the public what they are asking for, but to give them a right to live a traditional Canadian life.

Thank you for taking the time to listen and letting me speak in front of you today. I can say that this was an experience I will not forget. I think it is a good way to get youth more involved in society. I am not only someone who has come from a hard life in CAS; I have also tried and continue to try to survive in life, and I understand the struggle that most parents go through. I do not have kids, but I do live on my own and must provide for myself. It is hard, considering that you have to commit to a budget that barely gets you everything you need, but I do manage.

I think that Canadians need to stand by Canadians because we did not make Canada from one person; it was all of us combined that made this country. I believe that providing resources for youth and children will only result in good. If more recreation, after-school programs for teens, sports or even a club can get youth off the streets and doing something positive, that is enough for me to want to help build a community. I am not only participating here, but I've also spoken in front of homeless youth at Horizons for Youth, I tried out for the Dufferin Mall youth services, I speak at my school in the ambassador program and I also encourage my friends.

I really want to see Canada improve, not because I am Canadian, but for what the word meant for many people before myself: freedom.

Thank you once again. It was a real honour to have such an opportunity.

The Chair: Thank you, Talita. Does anybody else wish to speak?

Ms. Taneacha Campbell: Yes. My name is Taneacha Campbell and I am 26 years old, in my third year at the University of Toronto doing an Honours B.A., major in equity, minor in English and history. I've been on board for this bill for the last three years because I believe in what it stands for and I believe in the changes that it will make for the people here and others in Canada.

I just want to say thank you for giving us the opportunity to talk today. Being a former crown ward, I have experienced first-hand the effects of a system in need of repair, a system filled with holes and cracks which unfor-

tunately swallow one of our most precious resources: our children.

1810

From the moment a child enters the service of the Toronto Children's Aid Society, they enter a world of confusion. Who is my lawyer and what does this person do for me? How long am I under the care of the system, and just what do they do for me? Overwhelmingly, youth are concerned with the inadequacy of a system that is outdated.

There are three points I'd like to raise today.

Active communication between youth and their guardians: I don't know if you guys are really familiar with this, but as a youth, you enter care and then you realize that you have five people who affect your life, and they do not consult you. They consult one another through pieces of paper. You may be contacted at your foster home or your group home for about 10 minutes to see if you look healthy and if you're fine. They fill out some forms and go on with their business to determine what happens to your own life, without consulting you.

You have your lawyer, your worker, your foster parent or your group home staff and either a counsellor or a psychologist to determine what you think. In there, there is nowhere that you hear the child's opinion. I believe that this is a problem, because too many people are making the decisions for the youth. Decisions are not made on a personal but a professional relationship, resulting in confusion in the youth as to their role within the system.

My suggestions are:

(1) You could have an alternative resolution to decrease the stream of youth entering care, which would result in a smaller caseload for workers because, as we all know, they are overburdened; guidelines on what should be addressed with youth and follow-ups to ensure compliance to these guidelines; and programs to address life skills, such as appropriate and healthy relationship building.

It's wonderful that we have programs that teach young people about how to get a job and have a good resumé, but who teaches them who to spend time with? Who can guide them through life? Those are decisions that are left for them to make on their own. What usually happens is they look to alternative media, such as gangs. They see examples of what's going on on television and they try to live their lives that way. Most often, they end up back in the system as a problem.

The other thing is, increase the amount of information regarding the process of going through care. Allow youth to feel part of a system that says it is working for them. How can something work for you if it doesn't even consult you? That makes absolutely no sense whatsoever, and something needs to be changed there.

(2) Extending the extended care maintenance program: The problem is, currently, at 21 years of age, extended care maintenance is cut off. The majority of youth entering post-secondary education enter after the age of 21, meaning that when they're in school, if they start

school after 21, they will not have any funding to continue their education. Or, if they are continuing their education and it's after the age of 21, in the middle of their education they are cut off and left with nothing. They have to find a way to live and continue learning.

Also, the cost of living, the cost of housing and education have increased but the extended care maintenance has not increased. It hasn't increased in the last 15 years.

The solution: Increase the extended care maintenance to adequately reflect the growing need of youth in care and increase the cut-off age from 21 to a minimum of 25.

(3) Positive perception of youth in care: Currently the problem is that youth are being labelled and stigmatized within the social system, specifically in the educational system and within the police force. They are labelled as troublemakers, as though they did something wrong. You may not be aware of this, but if you are a youth in care and you go into the educational system and you're trying to tell people who is in charge of you or who your parents are, that's a very difficult process for a child to say, "I don't have any guardians. I live in a group home." Once you say there's a group home and once you start saying there's a court process, then it's like, "Oh, you did something wrong. What's wrong with you? What did you do? I can't hang out with you. My parents won't allow me to hang out with you because you're some kind of troublemaker."

The solution to this: Educate the community about youth in care; destigmatize the image of youth, primarily within the education system and the police force; implement a campaign that would use young people in care to describe care and their experiences within it; change the language you use to describe youth in care; incorporate the child's perspective into the decision-making process; and listen to the youth.

Finally, I would just like to say thank you for allowing me to express how I feel. I believe the system can be effective in aiding youth. The number of youth in care is currently increasing. In 1998, 50,000 youths were in care, and now it's up to 100,000. If something is not done to meet the increased number of youth within the system, there will be a burden on society and the general public will be those who will pick up the slack. Thank you.

The Chair: Thank you. The 15 minutes are already over, so there's no time for questions, unfortunately.

Ms. Wynne: Mr. Chair, on our list, the next speaker was to be confirmed. Can I just find out whether that speaker is—

The Clerk of the Committee (Ms. Anne Stokes): By teleconference, yes.

FOSTER CARE COUNCIL OF CANADA

The Chair: We can move on now to the next presentation. Can staff attempt to connect with the Foster Care Council of Canada, if they are on the line?

Mr. John Dunn: Yes, hello.

The Chair: Welcome. Is that Mr. John Dunn?

Mr. Dunn: Yes, that's me.

The Chair: OK, Mr. Dunn, you can start. You have 15 minutes in total. If you don't use the 15 minutes, there will be some comments or questions from the members. Please proceed.

Mr. Dunn: My name is John Dunn. I'm executive director of the Foster Care Council of Canada. That's an organization that is made up of people whose lives have been affected by foster care, who support each other and advise the public of important foster care related issues.

I know that members of the committee are interested as well in hearing from stakeholders in child welfare. I guess I could say I meet that need, since I'm a former crown ward of the Catholic children's aid society myself. I was in care for 16 years and moved through about 13 placements and seven schools. So I guess I meet the criteria for a stakeholder.

Moving on to Bill 210 now, I wanted to mostly address the amendments that are proposed to section 68 of the Child and Family Services Act with regard to the reduction in accountability that it would entail. One thing that I was mostly concerned with—I'm going to have to read into the record first the original and then the proposed changes. The original is how the legislation is today. It says:

"68(1) A society shall establish a written review procedure, which shall be approved by a director, for hearing and dealing with complaints by any person regarding services sought or received from the society, and shall make the review procedure available to any person on request.

"Idem

"(2) A review procedure established under subsection (1), shall include an opportunity for the person making the complaint to be heard by the society's board of directors.

"Further review by director

"(3) A person who makes a complaint and is not satisfied with the response of the society's board of directors may have the matter reviewed by a director."

The proposed changes are as follows, and then I'll go into detail on the parts that I want to talk about:

"(1) Every society shall establish a review procedure that satisfies the prescribed requirements for hearing and dealing with a complaint by a person concerning services sought or received by the person from the society, and shall make information concerning the review procedure available to any person on request.

"(2) A person may make a complaint about a service sought or received by the person from a society and shall do so in accordance with the review procedure established by the society.

"(3) A society shall not deal with a complaint under this section if the subject of the complaint is an issue that has been decided by the court or is before the court."

1820

To go into more detail now, the concerns I have are that with the original, the people had an opportunity to have their complaint heard by the independent board of directors of a children's aid society. Actually, I'd like to

back up and speak to the fact that it says "which shall be approved by a director." As it is now, the complaints procedure has to be approved by a ministry director. The new changes will not make that mandatory; it will be according to prescribed requirements, which I'm assuming are going to be regulations that won't have public input. That's one step of accountability removed.

The second part is that, where it says in the original legislation, "for hearing and dealing with complaints by any person," the new one says, "by a person concerning services sought or received by the person from the society." What this does is actually eliminate the ability of anyone who is not a client of a children's aid society to advocate on behalf of someone, so the only person who can launch the complaint is the client, and if they are extremely vulnerable or intimidated or anything like that, that reduces their support.

The other part is that the original legislation says it "shall make the review procedure available to any person on request." The new one says it "shall make information concerning the review procedure available to any person on request." This again further reduces accountability in that when a person makes the request for an actual copy of the complaints procedure, all they have to do is give information related to the complaints procedure rather than the actual complaints procedure itself.

These are obviously intentional changes that have a purpose, so I just find that an important thing to keep note of.

Where it says in subsection (2) in the original legislation "shall include an opportunity for the person making the complaint to be heard by the society's board of directors," in the new one it says, "a person may make a complaint about service sought or received by the person from a society and shall do so in accordance with the review procedure established by the society." Again, it says "the person" rather than "any person."

"Further review by a director

"(3) A person who makes a complaint and is not satisfied with the response" of the board can then have it reviewed by a director of the ministry. In the new one, they take that right out of there completely. It just says that the "society shall not deal with a complaint under this section if the subject of the complaint is an issue that has been decided by the court or is before the court." That in itself could be played around with; it's too ambiguous. Basically, the minute you become involved with a children's aid society, everything you talk about or anything from the point of involvement could become matters covered by a court. I just don't like the wording of that, specifically.

Something about dispute resolution that's proposed in Bill 210: One thing I've learned about dispute resolution is that everything in dispute resolution is to be confidential and cannot be used in court. I don't know if that's the same with this proposed legislation or if this child welfare mediation process will be a little different, if it could be somehow customized, but as a former crown ward myself, one of the largest issues I have is

confidentiality—not the fact that there’s not enough confidentiality, but that there’s too much. I’ve been trying for about five years, personally, to obtain copies of my own records from the children’s aid society, the Catholic CAS in Toronto, and they’ve been refusing me from the start. They won’t give me dentists’ names, doctors’ names, any of my medical records. So this is something that I think needs to be opened up.

I know the privacy commissioner supports, in her last year’s annual report, that records should be opened up or filed, at least pertaining to children’s aid. The Ombudsman recently spoke at a child and youth mental health conference. He also is, I guess you could say, *ad idem* with me on the issues around Bill 210 and accountability.

Those are the most important aspects that I would like to speak to. If anyone has any questions, I’d be more than willing to answer them.

The Chair: Thank you. There’s about five minutes left in the presentation, so we’ll have about a minute and a half each. We start with Mrs. Munro, if you have any questions.

Mrs. Munro: Yes. It’s Julia Munro speaking. I just wanted, first of all, to thank you for giving us the kind of thoroughness here in terms of the specific sections of the bill that you have concerns about. Certainly the fact that you have personal experience is really important to us to hear as the committee. We will need to look carefully at those areas of the bill that you’ve identified.

My own comment at this point would simply be that I’ll be looking at the Hansard of your comments to be able to look specifically at those areas, because accountability is always an issue that is very important in any process. Obviously, in a process that looks after vulnerable children, it’s even that much more important.

So I appreciate your presentation today and I will be looking at those sections you’ve identified.

The Chair: Thank you. Ms. Horwath, any questions or comments?

Ms. Andrea Horwath (Hamilton East): No. I too want to thank the presenter for making the comments, taking the time out of his day to do that.

I have to apologize for not having been here for the other presentations. I came in during a very powerful presentation and got to hear this presentation as well. I will look at the comments raised. I think the bill obviously needs some work, and we’re certainly here to hear from those people who are most interested and most affected by the children’s aid society and the crown wardship process.

I hope that at the end of the day we end up with a situation where we’ll have legislation that is going to be a positive experience, or at least legislation that will lead to a system that provides positive experiences for people. We can only do that with the kinds of insights and personal analysis and sharing that people like yourself are bringing to the table, and I thank you very much for that.

The Chair: Thank you. Mrs. Jeffrey.

Mrs. Jeffrey: Mr. Dunn, it was a little bit difficult to hear you. Are you submitting a written submission as well?

Mr. Dunn: Yes, I have. I filed one with the committee earlier. It was more or less a letter to the Ombudsman that has all the details in it.

Mrs. Jeffrey: OK. I had one other question. Generally, are you in support of the direction of Bill 210? You seem to have more concerns with the client complaint mechanism, mostly. Would you say that is an accurate reflection of your comments?

Mr. Dunn: I do. I kind of support parts of it too. I agree with kinship care and openness, just because of the way the system has been too rigid lately for minor things, non-abuse related, and that kids are being taken for those reasons. So I do support the family kinship care and alternative permanency plans.

The Chair: Thank you, Mr. Dunn, for your presentation.

At this point, I see Ms. Wynne has a question.

Ms. Wynne: Thank you, Mr. Chair. I’d like to ask the indulgence of the committee. The Office of the Child and Family Services Advocacy youth group, I believe, because they were the only youth who presented today—there was one presenter who didn’t get a chance to speak, and I’d like to ask the indulgence of the committee to extend by about seven minutes so we can hear from that presenter. I’d like to move that.

The Chair: OK. I will now take a vote, unless there are any comments. If the majority agrees, we can extend it. Comments?

Ms. Horwath: I think there’s been some criticism of the committee in terms of the amount of time we’ve been allotting for people, generally speaking. So I would hope that during the rest of the process of the public hearings, if we find there are people who don’t feel they’ve had an opportunity to have a voice—I certainly support having the young women speak to us today, but I would hope that that is a consistent expectation we can all have as members of this committee as we go forward through the hearings.

The Chair: Any other comments before I take a vote? If there are none, anyone in favour of the motion? The motion carries.

The youth group, if you wish to come forward tonight—I suspect we’re talking about another 15 minutes?

Ms. Wynne: Actually, I believe there’s one more presenter who wanted to speak, so I just ask for seven minutes.

1830

OFFICE OF CHILD AND FAMILY SERVICE ADVOCACY, YOUTH GROUP (continued)

The Chair: Please have a seat. Just tell us what you wish to, please.

Ms. Christina Alay: First, I would like to say that I feel very blessed and honoured that I’m here right now. This has been a dream of mine, and I’m actually in it.

Interjection.

Ms. Alay: Yes, and I have seven minutes for it.

My name is Christina Alay. I'm 23 years old. I'm attending the University of Toronto in my second year, majoring in sociology.

My life was hard, like all of us here. I endured severe physical abuse by my stepmother and my father. I was sexually molested from the time I can remember until I was 10 years old by my grandfather, and I was tossed back and forth between my father and my mother. The abuse my brother and I endured at my father's house is where children's aid became involved. I was in grade 5 when I confessed what was happening at home to a classmate and she made me speak to a teacher. I was really reluctant to do this because I thought, "I'm going to die if I tell you any of this."

My teacher called children's aid and we had an intake worker come in. After that day, I was taken from school to a family member's home and from there we were taken straight back to my parents'—my father and stepmother's—house.

We had, I guess, a permanent worker at that time. After my brother and I were placed with the protection worker, the violence in the home became worse because I had let out the family secret. I thought that I was finally going to be heard, but my worker made this impossible for my brother and me. After we would tell her the horrible stories of what would happen to us in our home, she would then disclose this private information to my stepmother. We would have to face the repercussions, which often were severe beatings and humiliation. I was even threatened with my life by my stepmother. She placed a large kitchen knife against my head, all because I disclosed the private secrets of the home.

I remember even disclosing an incident that had happened to me the night before to my social worker at a lunch she took us out to. The only physical proof I had was a large belt welt on my arm, which happened to last for years after that. She looked at me and told me plainly to my face, "What am I supposed to do with that? That's not enough." At that moment, I felt more alone than in my entire life.

Two weeks after that incident, my brother ran away from home because he forgot to take out the garbage and did not want to face the punishment my stepmother had waiting for him at home. The night before, he had endured the worst beating he had ever gotten. After he was discovered in my aunt's next-door neighbour's home, he was placed into temporary care. I did not see him for two weeks after that incident. My worker never came to visit to see how I was doing; the police never came to see if I was OK.

A month later, my father took me to my mother's home, from whom I had been separated for two years. Before I was posted to my father's home, I was living with my mom, who was a crack addict, and we lived in a crack house. The reason we left was because her life and our lives were threatened with a gun to her head in front of my eyes, that if she didn't pay up, he would kill us. So the next day, we went downtown. She overdosed, and

from there we went to my father's house, where the abuse continued.

Between all this, in the two years, my mother was contacted again. She was clean and sober, and there was talk of us getting back into the home. A month after my brother left, my father just dropped me off at my mother's house and never returned. I felt very displaced. I was not just leaving my father behind, but I was also leaving three half-siblings that I loved very much.

Within a few months or so, my mother arrived home from a day at court and told me that my brother would not be returning. He decided that he wanted to stay in the foster home. I was deeply hurt and felt betrayed by everyone. I was 11 at the time and had thoughts of suicide for the first time in my life. I would only see my brother once a month for six hours a day. That lasted a year, and then he was allowed weekend visits. In all of this, I was never asked how I felt about the situation. I was never involved in any meetings, and I was never told what was going to be happening to my brother, who is only 10 months apart from me. So he's basically my twin and basically my son, because there was nobody to take care of us—between an abusive, alcoholic father and a drug-addicted mother, there was nobody to take care of us except for us.

What I feel needs to be changed in the system is, first off, when abuse is happening to one child, 99% of the time it is happening to the other. There needs to be an immediate investigation into what is happening to the other child in the home. When my brother was taken into temporary foster care, like I said, nobody came to see what was happening with me. I was being abused severely after he left because I was labelled as the troublemaker because I called children's aid. I was labelled as the person who made my brother leave; I was the reason why he left and why he was put into foster care.

If a child is in temporary care and is being considered for foster care placement, have the family involved in the meetings, especially the siblings. I wasn't involved in any of these meetings. I was only told that he was going to be in foster care until he was 18, and he was only about 10 years old at that time. Let the sibling or siblings know exactly what is happening to the other sibling in regard to foster care. Have the sibling there during the court preparation so that the other one doesn't feel so alone. I can only imagine how lonely my brother felt because he didn't have me around. He told me that he would tell them in the meetings, "You don't understand. Nobody understands except for Christina. Why isn't she here?" He would plead for me, and still nobody would bring me to him.

Have the child who has not been placed in care get some counselling to deal with the feelings of separation. I was separated from everyone at that point. I didn't even know my mom; I was separated from her for two years. Two years for a child is a very long time. I felt as though, if I asked, I was being selfish, because my brother was the one in the spotlight, the one who was being taken

care of, the one who was abused and ran away and was in foster care. But I was being abused, too. I was the one who spoke up. I was the one who wanted help, but no help was coming to me.

When the child is placed in foster care, have it open to sibling visits on weekends so that we, as the siblings who are separated, don't feel like we are part of something so different, don't feel like, "You're part of another family and I'm part of this family. Now we're not part of the same family." Because of that, my brother and I were very close, but at the same time we were separate. He always tells me, "You don't understand what it was like. You weren't there. What do you know about being a foster kid?" And I don't know anything about being a foster kid because I was never there. I went there one time, and I felt very unwelcome. For a foster care child to feel more integrated into the home, they should have their family members come and visit them. Of course, there are safety issues and that which should also be put into consideration. But I was treated as though I was the abuser, like I was the one who treated him unfairly. But I wasn't; I was just his sister who wanted to be with her brother. I think I had every single right to have that, but nobody told me that I had a right to do that and nobody made me feel like I had a right to do that. I wasn't allowed. He used to tell me, "You're not allowed to come here," so I couldn't visit.

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When a foster parent considers taking a child, also consider the cultural background and implement some cultural activities or go to cultural events with the child so they don't feel totally displaced from their heritage or legacy. We are of Ecuadorian and Irish background. We were brought up in the Ecuadorian community and totally immersed in it. My brother was put into a Scottish home. Only now is he trying to find his cultural background. He has Ecuadorian features, but with very Irish skin and freckles, he has a hard time trying to find himself in the community. On the whole, how is he going to find himself without anybody telling him, showing him or helping him, even taking him to Spanish class on Saturdays? We used to go every Saturday—something so that you can feel part of your community again and you're not totally displaced.

When a social worker is obtaining confidential information from a child, keep it as such: confidential. If the information is disclosed to the perpetrator, there will be severe repercussions after the social worker leaves. That happened to me so many times. She would ask me what had happened. I would disclose it to her, she would tell my stepmother, and what do you think happened 10 minutes later? She would leave and I would be beaten again. I didn't feel like I was being protected at all.

When a social worker makes an in-home visit, when they leave, have them take a coffee break or something and then have them come back to check up on what is really happening in the home. In my case, nine times out of 10 they would have witnessed two children being severely beaten or emotionally abused for disclosing any

so-called private information. When my worker would come, my stepmother would make it look like the most perfect home that you could ever come to, the most perfect place that you could ever live in—fairytale land. But my stepmother would look out the window, watch that car leave, and as soon as that car would leave, she would actually make me pick out which weapon she should use, which belt she should use on me or my brother. She would beat us and beat us and beat us until there was nothing left for her, until she was tired.

As a sibling, I just want to say that the system isn't perfect; there's no such thing as a perfect system. But at the same time, there are a lot of things that need to be changed, like the things that I said. I know that social workers are overloaded and overburdened but, at the same time, these children are overloaded and overburdened with all of these things that are happening to them in their lives. We don't need to feel the repercussions of an overburdened and overloaded social worker. You're there to help me; I'm not there to be just a waste of your time. I'm human. If you're here, don't just say, "Oh, what can I do with that?" If there are laws or certain regulations they have to follow, sorry for my language, but F that. I was beaten every single day. Does that not mean anything? I'm 23 and I'm crying about it now. I didn't have a voice at that time when I was a kid. I didn't have a voice and I thought she could be my voice. But she wasn't my voice. She was against me; she wasn't for me. Now as a 23-year-old, all I'm asking is for you to listen to the recommendations that I've made and take them seriously, because I'm not the only one this has happened to.

Thank you very much for listening to me.

The Chair: Thank you for your presentation.

Ms. Brown: Can I say one thing?

The Chair: Yes.

Ms. Brown: I just noticed that in this whole room, there's older people, but for the people you're talking about, there should be—the majority in this room are the youth. It's our lives you guys are dealing with right now. The decisions you make are going to affect us totally down the line. If we don't have stability from somewhere, we can't help you build your country, we can't help you make this a better place, because it is the younger generation that's going to take it up after you, and if you can't look after that generation, then you can't look after this country and there will be no more country.

The Chair: Thank you for your comments. I think all of us appreciate how hard it was for you to express yourself. We will certainly keep your comments in mind. I think we are flexible, if any of you want to ask us questions. Otherwise, we thank you and we'll certainly keep everything in mind. Feel free to talk to any of us after if you want. Thanks for coming.

At this point, we will adjourn the meeting. The subcommittee may wish to stay because we have to make some decisions about next week. Thanks.

The committee adjourned at 1845.

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Official Report of Debates (Hansard)

Tuesday 6 December 2005

Journal des débats (Hansard)

Mardi 6 décembre 2005

Standing committee on social policy

Child and Family Services
Statute Law
Amendment Act, 2005

Comité permanent de la politique sociale

Loi de 2005 modifiant des lois
en ce qui concerne les services
à l'enfance et à la famille

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 6 December 2005

Mardi 6 décembre 2005

*The committee met at 1548 in committee room 151.*CHILD AND FAMILY SERVICES
STATUTE LAW AMENDMENT ACT, 2005LOI DE 2005 MODIFIANT DES LOIS
EN CE QUI CONCERNE LES SERVICES
À L'ENFANCE ET À LA FAMILLE

Consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts / Projet de loi 210, Loi modifiant la Loi sur les services à l'enfance et à la famille et apportant des modifications complémentaires à d'autres lois.

The Chair (Mr. Mario G. Racco): Good afternoon, everyone. Thanks for attending. Today we will continue our discussion of Bill 210. The first presentation is from the Grand Council Treaty No. 3 Nation, Grand Chief Arnold Gardner, if he is here.

We are going to have three groups speaking at the same time. In addition to Grand Council Treaty No. 3 are the Fort Frances chiefs' association and Weechi-it-te-win Family Services. The three groups will have a grand total of 45 minutes that you can share. Of course, for any time left, there will be the possibility for us to ask questions or make comments.

SUBCOMMITTEE REPORT

The Chair: But before you start, I do have to receive some information, so give me a few minutes, please. Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): I'd like to move the report of the subcommittee.

Your subcommittee met on Monday, December 5, 2005, to consider proceedings on Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts, and recommends the following:

(1) That the Ombudsman be offered 30 minutes to speak on December 6, 2005.

(2) That the clerk of the committee contact those groups who requested by faxed letter that the hearings be extended and determine how many are willing or available to appear on December 12 or 13.

(3) That if those requesting to appear can be accommodated on December 12 and 13, the clerk is authorized to schedule immediately.

(4) That if there are more witnesses wishing to appear than time available on December 12 and 13, the clerk will provide the subcommittee members with the list of witnesses, and each caucus will then provide the clerk with a prioritized list of witnesses to be scheduled.

(5) That those to be considered for scheduling first be those who contacted the clerk's office prior to the deadline on Thursday, December 1, 2005.

(6) That the time to be allotted to organizations and individuals in which to make their presentations be 15 minutes.

The Chair: Are there any comments on this? If there are no comments, I will ask for a vote. Anyone in favour? Anyone opposed? The motion carries.

GRAND COUNCIL TREATY NO. 3 NATION
LAC LA CROIX FIRST NATION
WEECH-IT-TE-WIN FAMILY SERVICES

The Chair: At this time, we'll go back to your presentation. You can start any time.

Mr. Arnold Gardner: *Remarks in Ojibway.*

I just want to make some comments in English. First of all, my English name is Arnold Gardner, and I'm the Grand Chief. Two years ago, the title was changed to a traditional one: Ogichidaa of Grand Council Treaty No. 3 Nation. An Ogichidaa, as best as I can interpret from traditional practice, is the protector of the people and the protector of the lands. That's the title that's been entrusted in me.

I represent 28 First Nations in northwestern Ontario, comprised of 55,000 square miles west of Thunder Bay to the Manitoba border, north to Red Lake and south to the United States border. There are approximately 25,000 aboriginal people in our territory. I want to note that the population of young people is growing at an astounding rate. Consider this in some of the presentations that we're making.

The other opening comment that I want to make prior to reading the presentation that I've prepared is that I think, in terms of consultations, it is a big one. It's understood, when we're talking about consultations, you'll hear from the communities that I certainly support a lot of the initiatives that were from our territory, from our

nation of Treaty 3. We do have a lot of things that are happening in terms of native child welfare: We have a lot of technical support, we've had systems in place for many years now and individual communities that have initiatives that we run. The knowledge, the experience that we have, we're going to hear about from my colleagues who are here today.

First of all, I want to say thank you to the Chairman and to the honourable MPPs around the table; to the people, the ladies and gentlemen who are sitting here today; and the honourable members who are sitting at the back. We thank you for your interest in this issue that's very critical to us as Anishinabe people. I want to say thank you publicly to the group from the Treaty 3 Nation that is accompanying me here today.

I'm rubbing my stomach against this thing here, sorry. I'd better move this thing up a bit.

This morning, I prayed for a good day. I prayed for all people in here, and I prayed for all the people in our vast land. It is a good land, and we have beautiful people living on it. It is something we all share.

Today, we are making presentations on the proposed amendments to the Child and Family Services Act. Bill 210 will have significant impact on First Nation citizens and communities who are not part of the native child welfare agency. It is by no means a surprise that we are opposed to this piece of legislation. We are also stating that we should be exempted from this legislation. However, that is probably unlikely, given the atmosphere surrounding the circumstances of First Nations people.

It is with this in mind that our presentation will outline our culture, our way of life, the Creator's sacred laws as the basis of our constitution, our traditional governance, and the child as a sacred gift from the Creator and our sacred responsibility to protect and provide care for that child. Our presentation will speak to the ethnocentric view which leads to the imposition of policies and legislation on First Nation communities; the proposed amendments; customary care practices; Anishinabe Abinoojii law; building on part X of the CFSA; administrative harmonization; designation process; and customary care technical capacity.

To begin the process, we affirm our nationhood. To begin, we do find it necessary for us to become known as to who we are as a people and as a nation. It must be hard for members of the standing committee to comprehend that a group of people who are subjected to imposed policies and legislation want to take the time to explain ourselves and to be known as a nation.

There are four components to being recognized as a nation: (1) people, (2) language, (3) land base, and (4) culture. We have all those. By being signatories to the treaty of 1873, known as Treaty 3, we acted and continue to act as a sovereign nation.

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Since time immemorial, the Creator granted to the Anishinabe the duties and responsibilities to govern ourselves. It is the traditional constitution—*Miinigoisewin*—of the Anishinabe, as given to them from the Creator's

sacred laws. Traditional Anishinabe law recognizes that the child is a sacred gift and that the best interests of the child is the paramount consideration in all matters relating to the child. The Anishinabe carry the responsibility to provide care and protection for their children and families. The child is a sacred gift from the Creator and represents the continuity of the Anishinabe nation. Traditional Anishinabe law recognizes that the child must live, belong and grow within an environment of human relationships rooted in the family, the clan, the community and the culture, and that these needs are essential to the best interests of every Anishinabe child.

Anishinabe culture comprises the whole accumulated knowledge and wisdom that has enabled the people to survive and to live a good life. Traditional Anishinabe law requires each Anishinabe person to protect and uphold the culture for the benefit of future generations, and gives the Anishinabe people guidance for their lives. Since time immemorial, the Anishinabe people have passed down to successive generations, and adapted for each generation, temporal law consistent with traditional law to meet the needs of successive generations as they may arise, including law for the care and protection of its children and families. The Anishinabe Nation in Treaty 3 has never relinquished or surrendered their sacred duties and responsibilities for their children and future generations.

The introduction of assimilation policies and practices had very negative impacts on the First Nation people in our territory. Alcoholism, loss of livelihood, and loss of culture and language contributed to family breakdowns and the erosions of the sacred duties and responsibilities bestowed upon the Anishinabe. Foster home care, residential schools and other factors led to the loss of parenting and family life skills, both in contemporary and traditional settings.

The culture and the traditions are regaining their stability in their practice. The Anishinabe Nation in Treaty 3 is getting stronger within the gifts of the Creator through the sacred laws and traditional knowledge. The child remains the gift of the Creator, and it is our duty and responsibility to provide care and protection.

In 1996, during the self-government discussions in our territory, which led to the signing of the framework agreement, the women in Lac Seul, one of the communities within our territory, stood up and insisted that child care be part of the discussions and be a priority. It was set and became a separate table to be regarded as a priority of the government and Grand Council Treaty No. 3.

Child care is a priority in our territory. For the past few years, we have sought to understand our sacred and traditional laws. We have developed a written law in a temporal form that will better enable our people, communities and agencies to regain the responsibilities and duties that are rightfully ours. It is also an opportunity to harmonize the laws of the provincial and federal governments with the sacred and traditional laws.

Section 35 of the Constitution of Canada entrenches our inherent right to self-government, which includes the

care of children and law-making authority. As a matter of fact, the Grand Council of treaty number 3 has enacted a resource law and has been developing a child care law.

To move forward in a respectful manner, we recommend that the amendments are geared toward strengthening part X of the CFSA. This would provide opportunity to provide better working relations between First Nations and the province. Our traditional laws plus your amendments would be a huge step in providing better care for our children and gaining a better understanding of our diversities.

I want to give my heartfelt gratitude to the many individuals, leadership and technicians who have contributed to this process and their undying belief that the government, through this committee, will understand that this type of working together is long overdue and that we must engage in focusing our efforts toward Part X as a step toward both of our visions.

Meegwetch.

The Chair: Thank you. Please proceed.

Mr. Larry Jourdain: First and foremost, I want to thank members of the committee for allowing me the privilege to speak before the standing committee. My name is Chief Larry W. Jourdain. For the record, I'm here for the Lac La Croix First Nation, not for the Fort Frances chiefs' association. My Anishinabe name is Maminotequenab. I belong to the Lynx clan. I belong to the Anishinabe, and I come from Lac La Croix. My profession is child welfare. Most recently—two years ago—my profession has become chief.

The subject matter to be discussed in my presentation is: the changes to the child welfare system in Ontario; their existing and potential impacts on the aboriginal community; ethnocentric preoccupation and the Indian and native provisions in the Child and Family Services Act, 1984 and amendments thereafter; and the experience and enterprise of the Lac La Croix First Nation.

There are noticeable periods of history that have had an enduring impact on the aboriginal community, and in particular on the aboriginal socio-cultural systems and structures, which include the customary family system. The historical evidence and research indicate the degree of the damage and the extent of incapacitation of these vital socio-cultural systems and structures. The introduction of a different set of socio-cultural systems and structures began the deconstruction of the customary aboriginal family system. This process of deconstruction advanced to the residential school system and was later transferred to the child welfare system. The deconstruction and its impact are well documented and it is both too lengthy to discuss here and not up for consideration by this committee.

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Child welfare services were not extended to the aboriginal community until changes occurred to the Indian Act in 1958 which permitted provincial authorities to have access to federal lands. The signing of the memorandum of understanding in 1965 outlined the permissible services and the payback scheme: For every dollar spent

in child welfare, \$91 is paid back by the feds. This began the involvement of the child welfare system with aboriginal communities and families, and their overzealous efforts resulted in the 1960s scope.

Another significant development was the enactment of the Child and Family Services Act, 1984, which included Indian and native provisions. From 1984, aboriginal communities have had the opportunity to develop their own family service authorities. Currently, there are six aboriginal societies and four agencies. Interestingly enough, four aboriginal societies are situated in northern and northwestern Ontario—our understanding of geography; we're further north than Barrie—with five aboriginal agencies in central Ontario and prevention programs in southern and southwestern Ontario.

From 1998 to 2000, the child welfare system experienced a major makeover in a process that has come to be known as child welfare reform. These changes resulted in the following: legislative changes; a new funding framework; mandatory risk assessment tools; a standardized approach known as the Ontario risk assessment model—in my profession, ORAM; a fast-track information system; and the revitalization of foster care.

In 2002, the child welfare evaluation was initiated and it resulted in the following: stronger emphasis on outcomes; investment in research; development of a single information system; and more attention to shared services and infrastructure. The evaluation encouraged: less reliance on court interventions; implementation of Looking After Children; clearer and stronger connection with children's mental health services; a differential approach to intake and assessment; rethinking of the funding approach; and an increased recognition of Indian and native provisions. The evaluation included an interjurisdictional review.

In 2004, the Child Welfare Secretariat was created to advance the recommended changes. Their key foci include: system service redesign; differential response; permanency strategy and court processes; accountability linked to outcomes; comprehensive research and evaluation agenda; a single information system; and a multi-year funding arrangement.

Although the changes to the child welfare system are refreshing, there are existing and potential impacts to the aboriginal community.

The child welfare reform in 2000 resulted in a moratorium not to designate new aboriginal societies and agencies, effectively halting our aspirations and any further development. The changes to the Child and Family Services Act included the lowering of the paramount status of entitlement to have services provided by our own child and family services. The purpose dropped from second to the last and fifth purpose. This is not surprising, because it created the premise for a policy framework to implement changes that completely ignored the Indian and native provisions and any involvement of the aboriginal community.

The funding framework and the Ontario risk assessment model failed to take into consideration the

socioeconomic realities and geographical distances of northern Ontario; completely dismissed cultural determinants in aboriginal child welfare practice. The lowering of the protection threshold and a new pattern of neglect resulted in higher apprehensions. The new emphasis on permanency planning led to hasty decisions and no time available for family reconciliation. The standardization of child welfare practice is simply culturally destructive and assimilative. The aboriginal community has rejected the new changes and called for greater involvement, warning the child welfare system that the changes would bring a new millennium scope and increased costs.

All of these outcomes have come to be true, as the child welfare system is now attempting to adjust to the unexpected results. The total number of children in care has increased 66%. Crown wards have increased 92%. There is \$1.1 billion in expenditures. There's an increase of 41% in the ongoing case load for CASs, a 51% increase in investigations and, it should not be surprising, an overrepresentation of aboriginal children in the child welfare system. As a matter of fact, aboriginal children in the care of the child welfare system have now drastically surpassed the number of children that were in the residential school system, as a national average.

In response, the child welfare apparatus initiated the transformation agenda. Aboriginal child welfare practitioners and researchers have been attempting for some period of time to get the attention of policy-makers and promote culturally competent and congruent aboriginal child welfare practices. There is some indication that someone may have listened to the advice: openness agreements, differential response, prevention focus, safe home declarations and relative placements, family preservation models, kinship care and alternative dispute resolution are all well-established practices in the aboriginal community. These practices are being promoted by the transformation agenda as the new change.

Although the transformation agenda and its recommended changes are a welcome change to an antiquated system, there is cause for uncertainty in the aboriginal community. At this time I would really like to thank Bruce Rivers and his team at the Child Welfare Secretariat for their involvement in these changes.

The new changes to the Child and Family Services Act lack any involvement of the aboriginal community, and in particular the band, and do not enable culturally competent and congruent approaches as the original version in 1984 appears to have done. The sections dealing with alternative dispute resolution and service complaints do not include traditional systems as a vital process for reconciliation. The section dealing with assessment is discerning, because of the authority given to clinical practice without due consideration for culturally competent and congruent approaches. The sections dealing with placements and post-adoption agreements do not include any provisions for the involvement or notification of the band representative.

The sections dealing with crown wards need careful reconsideration: Any access order is automatically ter-

minated; no notification or participation provisions for the band representative. Reviews do not include the band representative; however, legal representation for a child in ADR and openness processes is permitted. The sections dealing with the standardization of service are problematic, because these provisions may be applied to isolate and regulate societies and agencies that are practising in a manner that is outside the expected child welfare practice.

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The most discerning section is the section that gives authority for making regulations that will govern procedures, practices and standards for customary care. There is no indication in the act if there is going to be any involvement of the aboriginal community in the development of such regulations. Failure to involve the aboriginal community in meaningful consultation and participation will lead to major discontent, possible legal actions and possible revolt to the child welfare system and apparatus. At a minimum, the new changes must legislate a consultation requirement with respect to customary care.

Both the reform and the transformation agendas have been preoccupied with an ethnocentric approach and only paid attention to enabling and advancing sections of the act that deal with conventional child welfare practice. Any validity that would promote or enhance the Indian and native provisions has been completely ignored.

There are 31 Indian and native provisions in the act, an exclusive section commonly referred to as part X, and a provision for exemption in part XI. These provisions obligate the courts, ministry, bands and societies to a multi-party practice and extend authority to the band to be involved and participate in child welfare proceedings.

It is safe to assume that the Indian and native provisions have never been fully understood or applied by the child welfare system or apparatus. Any compliance reviews have never taken into account any adherence requirements for the Indian and native provisions. Most recently there are signals that minor attention is being paid. The extent of application of the Indian and native provisions in the judicial process or in child welfare proceedings remains unclear and questionable. A judicial review may be warranted.

The potential of the Indian and native provisions to be able to contribute to the reform and transformation agendas has not been explored, examined or considered. The potential to expand customary care from a voluntary service to a service response that includes the development and implementation of community codes for involuntary proceedings and custom adoptions has not even made it to the radar screen of the transformation agenda. Instead, kinship care has been quickly advanced and has been introduced as a preferable model.

The Chair: It's eight minutes, and there are two more speakers. It's up to you how you want to use it.

Mr. Jourdain: OK. I will go quick.

The Indian and native provisions include the ability of the aboriginal communities to develop family services

authorities and for the ministry to negotiate the delivery of these services. There appears to be no requirement for these authorities to become societies or agencies. This has been a ministry practice. Now there is a designation process, but the process remains absent from the act or regulations.

The Anishinawbe community of Lac La Croix has been concerned about and dealing with social deviance, including the care of children, for some time. The community has been implementing customary healing strategies aimed at improving the quality of life for our children and families.

The community is a proud and progressive traditional Anishinawbe community. The people insist on and expect social services to be biculturally proficient, culturally competent and congruent. Any other form of service is not relevant, and is harmful to the community.

A few years back, the First Nation had negotiated a project with then-Minister Tony Silipo to deal with sexual abuse. The project was a success, leading to the development of the Rainbow of Healing, an aboriginal treatment model; Anishinawbe Way, a community model for child welfare; community code development, developing a code for customary care; a sexual abuse program, a community model for managing sexual abuse; and Akwiinoowin, an integrated social services model. However, the loss of the NDP led to the loss of financial resources and, eventually, closure of the program.

Some remnants of the program continue to exist, implemented with the assistance of Weech-it-te-win Family Services. The rest of the province may indeed benefit from such models of healing.

Lac La Croix is serious about protecting our children. The council has instructed Akwiinoowin to track all our children outside of Weech-it-te-win. Despite these concerted efforts, we continue to lose our children. The most recent was a crown ward who died from a degenerative disease while in the care of the CAS. The family wanted interment in the community with a traditional burial; the CAS and foster parents objected. The ministry advised the band that they would not intercede and they would strongly support their agent, the CAS. The matter went to the courts and the CAS was awarded judgment. Even in death, the CAS seems to have the final say.

The CAS used the female sibling of the child to defend their position against the band. The girl has since turned 18 years old and has returned to the community of Lac La Croix, where she now makes her ordinary residence.

No matter what type of laws, regulations and directives are developed to restrict interaction and keep the children away from the aboriginal community, they always come home. Wouldn't it be easier to legislate expanded and enduring Indian and native provisions?

I have spoken.

Apichi Gitchi Meegwetch.

The Chair: Thank you. Mr. Simard or Madam Stevens, you have about five minutes left.

Mr. George Simard: Five minutes?

The Chair: Yes. Before you proceed, may I recognize Madame Horwath.

Ms. Andrea Horwath (Hamilton East): Thank you, Mr. Chair. I'm just thinking of the committee meeting yesterday, where we had a few minutes of an extension because there were a few people whose voices were important to hear. We extended the hearings by a few minutes yesterday afternoon. I'm wondering if we could allot the same consideration to this group, which has come from so far away to provide us with their insights and their experience and their important points.

The Chair: It's up to the committee. As the Chair, I try to obey the agenda, but if there is support in every corner, I think we can do it. Is there support, if necessary, to extend? We have to keep in mind that there are people waiting, so let's not waste too much time debating it. Why don't you proceed, sir, and then, if necessary, we'll add a few more minutes.

Mr. Simard: What we're trying to convey to the standing committee—and I'm sorry for not acknowledging you; I do that now. We're trying to tie in for you and give some graphics to the verbal that has been presented here. What we're trying to demonstrate to you is, over the 20 years that Weech-it-te-win has been on the ground, in the trenches, providing First Nation child welfare services, how we visualize our communities in relation to their regard for their children.

We draw these circles in this fashion here—the child is the centre—and various layers within the community have responsibility, as our grand chief and Chief Jourdain have said, about caring for those children. So you see the child, the biological family, the extended family, the First Nation community and then Treaty 3 as a whole in relation to how we visualize the system of caring.

What has been perpetuated on us, however, is not to utilize these layers of security and protection within our system. What has prevailed is the mainstream practice to rip that child out of that protective environment and traumatize them again by putting them in a non-native environment. Generally what happens with that is we get them back at 16 as damaged goods, something that we refer to as a split feather syndrome.

As a result of our women, as the chief has mentioned, Treaty 3 has decided to initiate their own process in terms of creating their own Anishinabe law for child care in Treaty 3. That process began in 1996.

1630

Being a technical person, then, in order to make it palatable to the government, we had to start inventing words so they would understand the concepts that we're trying to promote. We talked about harmonization and we talked about world view, but there are a number of paths to the Creator. Catholicism is only one of them; the Anishinabe way is another one. I heard that from a Jesuit one time. When we talk about CFSA mainstream practice and our Anishinabe law that has now been created, we're talking about an administrative harmonization that has to prevail, and that's what that diagram is trying to demonstrate.

Further, to try to convey our message to the people, this is how we visualize Weech-it-te-win. Yes, we have a designation from the provincial government. It is secondary to our caring for our children under our inherent right. So what we've done is used Anishinabe tools and mainstream tools, what we call our bicultural practice, to reach the same end that you have related to the protection of children.

How we continue to measure that in relation to its compliance: We take in the statutory care provisions under the various orders, in terms of their policies and procedures and file compliance, and what we've done under customary care, part X, is Weech-it-te-winized it, adopted them and built our own compliances in that regard. What's significant about it is that they still use their regular, mainstream tools to come and evaluate us over here. It's another way of looking at our manner of practice. When a client comes into Weech-it-te-win seeking service, our workers, in order to operationalize this bicultural practice, must be proficient at providing what we call the Anishinabe Way, which are those traditional practices related to our healing that have been historic to us and that we implement.

We do not negate, however, that there is an acculturation that has gone on with our people, so we provide those supports to them as well. These yellow lines represent the levels of acculturation that an individual may have. So a person can come in and access mainstream practice if they want it at Weech-it-te-win, but if they want to go see a healer or have a shake tent consultation, they have the privilege to do so also.

Appreciate that none of this is necessarily funded or acknowledged under the current funding framework. As a matter of fact, related to our subsidies under customary care, they are not even recognized in the current funding framework. We have to use subterfuge and temporary care agreements in order to have those subsidies funded.

In order to empower our First Nations people, this is the process of our placement. We use the immediate family and the extended family. You'll notice here that it's somewhat contrary to the usual practice of removing the child into a non-native environment. That is one of our last resorts. I say to you that we do consider that, we're not averse to that, and we thank our white brothers who provide that service to us from time to time, but we want to emphasize this: As far as we're concerned, related to our aboriginal children, they are in fact citizens plus, and these then are those rights that are beyond the regular rights that you see offered to a child in care in mainstream practice.

We are saying that an aboriginal child has a right to his Anishinabe name. There are Ojibway words for what that means. It predates any legislation. I'm talking from that premise as well. Understand that these things are in the language. They predate any CFSA that has ever prevailed. We're saying that that Indian child, because of his identity, has to know his spiritual name and he has to know what clan he comes from. He has to have an identity. He must know his language and he must know

about his cultural and healing ways. He must know about the good life that's part of everything that we believe in. He must have ownership of his land. He must have an Anishinabe lifestyle. He must have an Indian education. In "protection," these are the Ojibwa words that emphasize the various essence of care in our communities. He has a right to his family. This is what we mean related to special rights for our kids, which we believe, through the 1965 agreement, we are paying for 91 cents on the dollar.

In that regard, then, I'd ask you to consider this in terms of this concept of administrative harmonization. You have the CFSA in relation to its various parts. We too at Weech-it-te-win, in terms of our customary care, are beginning to develop our own parallels, if you want, related to your legislation.

What we want to say is this: Will you not consider this on behalf of these children that I represent? We're asking you to build on part X, to work with us, and we extend our hand to this committee for that purpose. We want you to consider building on part X as an interim measure. We know that this ethnocentric world view that you have primarily concerns itself with mainstream practice, and that's OK. We understand that; that's where you are. What we're suggesting to you is that in part X, which is also within the legislation, we are prepared to take those amendments and adopt them. We are also prepared to take our Anishinabe laws, as declared, and lend you some of that knowledge into part X, to build part X. But make no mistake, as far as we're concerned, that is an interim measure, because the ultimate goal is to have our own stand-alone law declared in Ontario by 2010. That's what the chiefs have authorized.

So I say this to you, and please appreciate it this way: Customary care to us is about our life. Customary care was not designed by the Child and Family Services Act. It is a concept we use to develop our services. It is much bigger than part X, but part X does give us an opportunity. It's broad enough for us to start a process of our own governance.

What is our ultimate goal? To rebuild and revitalize the core of Anishinabe society and structures. This is the self-governing aspiration of our First Nations: "Self-government is our right as a people, a gift from the Creator." This is what our people are saying.

In closing, we want to honour these men who, in the 1970s, began a process of healing child welfare in our territory: Moses Tom and Joseph Big George. We're grateful to them for their perseverance in pushing this agenda.

For the children of Weech-it-te-win, we say to you, miigwetch for listening.

The Chair: Miigwetch. Thank you to all of you for your presentation. We went over by seven minutes, which is fine. The committee agreed. We'll move on to the next presenter, if you don't mind.

Mrs. Linda Jeffrey (Brampton Centre): Is there a chance to get a copy of their presentation today?

The Chair: The last presentation? Yes.

Mrs. Jeffrey: Can we get a copy of the written presentation today? Is that a possibility?

The Chair: Yes. I think we have two pieces already. The last one we don't have, to my knowledge.

Mr. Jourdain: To extend my hand, I give that to you as part of building our relationship.

Mrs. Jeffrey: Perfect. Thank you very much.

The Chair: Mrs. Jeffrey will share that with all of us. Maybe the clerk could get it, and then all of us could have a copy. We thank you again for your presentation.

Can we move on to the next presentation, Aneurin Ellis?

Interjection.

The Chair: Yes, Mr. Hampton.

1640

Mr. Howard Hampton (Kenora-Rainy River): It would have been good to have had an opportunity to ask a few questions. I don't think we're going to see information presented by anyone else like this. As is clear from their presentation, there is a lot more here than has been discussed heretofore.

The Chair: I hear your request. Again, as the Chair, if there is support, I will certainly allow that. We've got to keep in mind that we are behind by almost half an hour, but that's fine with me. There are people waiting. Is it the wish of this committee to extend and allow some questions? Do I hear any comments? Otherwise, I'll ask for a motion and we'll take a vote.

Ms. Horwath: Perhaps even just one question from each party would be helpful.

The Chair: A minute each, you're suggesting? Could the four of you please come over here? What we are going to do is allow only one question for each party, one minute in total between the question and the answer. If all of us can keep that in mind, please, mostly because there are other people waiting. Mr. Hampton, would you like to start, and we'll go around?

Mr. Hampton: I do have a question. My question boils down to this: I think Mr. Jourdain and Mr. Simard both indicated that the child and family service organization they work with, Weech-it-te-win, is audited from time to time by the ministry to determine to what extent they are meeting the objectives of the Child and Family Services Act. I want to ask them, to your knowledge, are non-aboriginal child and family service agencies ever monitored or audited to determine to what extent they are meeting the cultural needs of aboriginal children who from time to time may be under their authority?

The Chair: If you can answer, please.

Mr. Jourdain: Not to my knowledge. I said in my presentation that certainly there are signals that the compliance reviews now do pay small attention to those provisions in the act, but not to my knowledge, no.

Mrs. Jeffrey: I don't have a question, but I guess I would agree when Chief Gardner spoke about how he prayed for a good day. This is really important, and I know that the ministry supports customary care. We're going to try and do as good a job as we can. I think everybody around this table believes that the safety of

children is paramount, and I'm very grateful you came today. You spoke very well, all three of you. Thank you.

Mrs. Julia Munro (York North): I want to also add my thanks for you coming here and coordinating your presentation. I think that was very effective for us to get a full picture of some of the issues. I look forward to reading the presentations and also looking at the areas where we might be making recommendations for amendment.

The Chair: Thank you again for your presentation.

FAMILY SERVICE ONTARIO CATHOLIC FAMILY SERVICES OF PEEL-DUFFERIN

The Chair: At this time, we will ask Mr. Ellis. Is he here? Would you please have a seat, and while you get ready, I'll just remind you that you have a total of 15 minutes for your presentation. If there is any time left, there will be comments or questions for all three parties. So you can start any time you're ready, please.

Mr. John Ellis: Thank you very much. John Ellis is my name. I'm the executive director of Family Service Ontario. With me is my colleague Mark Creedon, who is on the board of directors of Family Service Ontario and who is also the executive director of Catholic Family Services of Peel-Dufferin. We are both going to speak to you this afternoon—me, relatively briefly; and Mark will finish after I have completed my remarks.

First of all, I would like to thank the committee for giving us this opportunity to present to you. From the perspective of nearly 50 family service agencies in Ontario—

The Chair: Just for the record, you are Mr. Ellis?

Mr. John Ellis: I am.

The Chair: You are here representing Catholic Family Services of Peel-Dufferin and Family Service Ontario, which is not the next presentation. It's a few down. That's fine. We'll continue with your presentation. There is also another Mr. Ellis, but that's fine. You can proceed. We just want, for the record, to—

Mr. John Ellis: OK. So anyway, we are Family Service Ontario, which is a provincial umbrella body representing approximately 50 family service agencies in the province, of which the Catholic Family Services Peel-Dufferin is one.

We have basically three things that we do as a provincial body. The first is to provide a number of specific services to our member agencies. That includes educational and information opportunities.

Second, we have an accreditation program, and I might mention to the committee member—I think it was Mr. Hampton who asked a question about whether family service agencies are monitored. This is a very timely question because one of the services that we offer to our member agencies is an accreditation program. You're probably familiar with the hospital accreditation system, and there are other similar ones around the province. But

the fact is that we also have a very sophisticated accreditation program for our agencies. As part of the standards, they are required to show that they are not only sensitive but they also offer services to multi-ethnic communities. This is part of the requirements of accreditation. I thought that might be useful information pursuant to the last question.

The third thing we do is advocate on behalf of our agencies for improved legislation, policies and funding.

The Child and Family Services Act is a very important part of the reform of child welfare that's currently taking place in the province. Its goal of helping children and families is very consistent with our goals as well. It's a complicated reform process, and includes differential response, permanency planning, adoption, customary care and alternatives to court, and the concomitant and supporting activities of quality assurance, evaluation, management information systems, funding models and training.

Family service agencies in the province are very pleased to be part of this reform process and see our agencies playing an important role in attaining its objectives. In her message introducing this legislative reform, the previous Minister of Children and Youth Services, Marie Bountrogianni, said the following: "Legislation should reflect the values held by the people of Ontario and provide the appropriate tools for professionals to carry out their work." We wholeheartedly agree with this statement.

The two key conclusions drawn from the legislative review that are most closely related to helping the children and families supported by family service agencies in Ontario are the following: (1) increase supports and services available to families to prevent the need to take children into care; and (2) integrate and coordinate children's aid society services and programs with other community services. Children's aid societies are not mandated to provide counselling support to families and are currently preoccupied with protection and investigation activities.

Referrals to family service agencies are made to help many families at risk who come to their attention, but there is no accompanying funding. In fact, core government funding for these family support programs was taken away from the family service agencies in 1995, as many of you know. Without the restoration of this funding through legislation, this reform cannot be implemented successfully. Provisions in the act have to include the funding of such support services.

The good news is that now there is an opportunity to rectify this situation with the effective implementation of the differential response model. Family Service Ontario and our member agencies would like to see reference to this in the legislation. We support the goals of this model as evidenced in our submission to the Ministry of Community and Social Services in response to its discussion paper *Linking Child Welfare and Social Services*. This model integrates the identification of children at risk, seeks the support of local agencies like family service

agencies and, where appropriate, works with them to strengthen the families.

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The results, as demonstrated in the research done in the United States, Australia and Alberta, show that the number of children coming into care is reduced, that recidivism of referrals to CAS declines, and that the pressure on the health, mental health and criminal justice systems diminishes. These conclusions can be drawn also from the results of the Safer Families project in Peel region, which is based on the differential response model that Mark is going to talk to you about momentarily.

These are our mutual goals, and family service agencies look forward to playing an important role in the new paradigm.

Now I'd like to ask Mark to make some further remarks pursuant to my presentation.

Mr. Mark Creedon: I'd like to thank all the committee members for inviting us here. I'd like to say a special hello to Linda Jeffrey and Peter Fonseca, who represent Mississauga and Brampton. We have offices in both.

The reason I'm here is because I'm the executive director of Catholic Family Services of Peel-Dufferin and also because I was asked to represent Family Service Ontario on the Child Welfare Secretariat reference group. I think the reason I was asked to do that is because I spent the last 16 and a half years working in family service agencies and the prior 13 and a half years working in child welfare agencies. When the province began to look at where a differential response could make sense, I was asked to represent both of those sides of the same coin.

Just to give you a very quick understanding of the kinds of things that a family service agency does would take too long to explain in this short amount of time, but I think there are certain core services that are provided in each of the 50 family service agencies throughout Ontario, and that would be individual, couple and family counselling. Unfortunately, it's a reality that something like 50% of marriages are going to get into serious trouble, according to Stats Canada, and a third of them are actually going to pull apart altogether, and that's without help—the kind of help that family service agencies can provide. Many families get torn about in the same process. Some 29% of women are going to experience some form of woman abuse in their lifetime in their relationships. Adult survivors of childhood abuse: about 15% of women and 10% of men are sufferers of that. These are some of the core services that family service agencies provide.

I think that Bill 210, from my experience in looking at it, is an excellent bill, because it really tries to balance the two priorities that a children's aid society has: the first one to protect children, and the second one to enhance the wellness of children by supporting their parents. My fear is that in the last 10 years, that last priority has been given very scant help. In looking at Bill 210, it reminds me of going back to the future. It looks a lot like the kinds of things that child welfare was doing in the 1970s,

1980s and the early 1990s, only it has got better tools now, so it still is an advance into the future.

One of the things that Bill 210 will do is encourage the natural partnerships between child welfare and family service agencies. There's a family service agency located pretty much in every region of Ontario where there is a CAS. In the 30 years of my professional social work experience, I don't think a day ever went by that I didn't see a family that was involved in child welfare that couldn't use the kind of services that family services could provide. So often, those families have really blossomed and really grown when they've been given a kind of a counselling program based on their strengths.

I think what I'll do with the last two minutes is just talk a little bit about an example, which is Safer Families. Safer Families is a partnership between Peel CAS, Family Services of Peel, and Catholic Family Services of Peel-Dufferin that tries to get services very quickly to survivors of woman abuse, the children who witnessed the abuse and the men who committed the abuse. The family service worker goes out with the CAS worker and tries to engage. There was a pilot study done with 15 families; 14 of those 15 families decided to stay working with the family service agency after the initial time that they met. There was a 32% lower re-referral rate in this pilot study. There was a four-month-less time spent with the CAS and there were three children who were clearly prevented from coming into care as a result of it.

When you compare how things were done before this kind of differential response—let's say the neighbours called because a man had been yelling at his wife for an hour. CAS would go out, but because of the eligibility criteria, they wouldn't be able to force the family to stay involved. Maybe two months later, they'd go out again, and the man would be yelling for two hours, but again the woman is afraid. She doesn't ask for help; she's afraid to do that. CAS has to go and close the case again, as do the police. Finally, he throws her out on to the front lawn, but he doesn't cause physical harm, so again, the family does not have to stay involved. Another two months goes by, and he does her harm: He sends her to the hospital. Now he's charged. Now the woman goes to the hospital. Possibly the children's aid society has to take the children into care. There are tremendous taxpayer costs, but more so, tremendous harm to the family; the children have been exposed for months.

I believe that Bill 210, in many regards, will give the kind of flexibility to the children's aid societies and community agencies to really give families the right kind of service at the right time at the right cost. I think, like all bills, the ultimate test will be: How well is it managed, and how well is it funded?

The Chair: Thank you. There is no time left for asking questions, but thank you for both presentations.

ANEURIN ELLIS

The Chair: So that I can get back to the agenda here, Mr. Aneurin Ellis is coming in. You're next, sir. You

have 15 minutes in total for your presentation. If there is time left, we will ask some questions. Please start whenever you're ready.

Mr. Aneurin Ellis: Good afternoon, everybody. I'm really pleased to be allotted 15 minutes of your time. I do appreciate it.

I come before you as a father, a husband and a man who has taken on the non-traditional role of stay-at-home dad. I've been a stay-at-home dad for quite some time, since my children were born, basically.

We're here today to address amendment 26 of Bill 210, which changes the way the societies deal with complaints. We believe the amendments do not go far enough to protect children; in particular, subsection (3), "No review if matter within purview of court."

We had our own personal experience with family and children's services, with the society. We filed a complaint early in their dealings with us. The complaint was filed back in December 2002, and to this very day we still haven't been able to get through to their third step, which is their board of directors. We've been turned down over and over again for the last three years. We've made numerous attempts, then requesting a meeting with the ministry, and we've been able to do that.

My concern with the complaint procedure is that in some cases it takes a couple of years. In our case, it took our case about two years before we were able to get to trial. Our complaint issues were the issues that were at court. In situations where the society fraudulently brings a case against a family, like in our case they have, and what I mean by fraudulently bringing a case against somebody—in particular, my wife had called the police, and therefore the police were involved. We're all together to this very day, but the police got involved and I was arrested. The charges were eventually withdrawn, but the police were involved; the society was called.

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I was released on the condition that I should go to counselling, which I had no problem with at all. I'm quite a reasonable person. It was very important to me. I believe most reasonable people would see that if someone has addressed a concern to you regarding the well-being of your children, and you're willing to recognize that concern and you're willing to do something about it, address it and maybe make some changes in your life if necessary, that would be a good thing, a positive thing, you would think. In this situation, even though I was willing to go to counselling, they opened up a case and put before the court that I wasn't willing to go to counselling, and were able to obtain an order to apprehend our children.

A few days later, after that apprehension, they took my little daughter here and were able to question her over a period of—I don't know, because we had no contact with the children; we didn't have any contact with the children for six days. What I mean by no contact is that we had no phone calls and no physical contact with our children. We had requested that our children have contact with our friends and families; we requested that the

children have contact with a doctor. The society said no. We also requested that our children have contact with the daycare supervisor. The society said no.

This went on for six days. At the end of six days, the police called me, asked me to come down to the police station and charged me with a terrible crime against my daughter, a sexual assault crime against my daughter, the most horrific type of crime you could ever be accused of.

Over this period of time, these six days, there was a video interview that basically consisted of two video interviews and also an off-camera interview where in the third interview, let's say—that we know of—the worker enters the room, kicks the chair out of the way, sits down beside my little sweetheart here, and she would ask her these questions. Well, she actually didn't even ask her the questions. She basically said to her, "Now, during the break," when the camera was turned off, "you had said certain things about your Daddy." She just repeated exactly what maybe—who knows?—they wanted her to say or whatever.

The bottom line is, if anybody had any concerns regarding a sexual assault on anybody, especially in the nature of this sexual assault that apparently took place against my daughter, you would think that someone would take the child to a doctor, a psychiatrist. They had my daughter there for three months. You would think this would be important, some kind of examination, but that wasn't going to happen in this situation for some reason.

Anyway, they were able to be successful in removing me from the home with regard to that. It took a period of 10 months before the charges were withdrawn and everything else. But what I'm trying to say here is that there's a problem with the complaint procedure, being that it's taken our complaint three years to get anywhere. The other problem is that if you're going to wait for a court proceeding to end, the issues in the court proceeding may be related to the complaint. The complaints have to be addressed, because the well-being and the protection of a child has to be paramount, and it has to be paramount even if it is protection from the society. These children have to be protected. It's the responsibility of the government and the people who make the laws in this country to put in place protection laws for our children, even if the society or organizations or agencies intend to exploit children for whatever gain. For me, it's totally beyond my imagination. It repulses me. What is the gain, what is the purpose for these types of actions?

The other thing is that when I reported these allegations that I'm bringing to your attention this very day, the director of the children's aid society filed a lawsuit against me for \$500,000. On the very same day while we were going to court, while we were in a court proceeding, on the way to trial, the director filed a lawsuit against me for \$500,000 and apprehended my two children on the very same day. In his affidavit of that lawsuit, he indicates that the reason why the lawsuit was brought against me was to teach me a lesson. Now, if he's filing a lawsuit against me and taking my children—it's absolutely insane to fathom what has actually taken place

here. It's very difficult to believe. Then, when we went to court—because we had to take it to trial. We didn't have our children; they apprehended our children. We proceeded to trial, and while at trial—my wife was pregnant. The trial ended on May 27, 2004. My daughter here was born on May 20, 2004, but while at trial—this trial took three months, and we were defending ourselves, because it's extremely expensive for a family. It can certainly break a family, and actually make you bankrupt, trying to find a lawyer. We went through five lawyers. I had two criminal charges against me; they were both thrown out by the crown. We went through all of this, and while we were at trial trying to get our children back, they started sending us letters threatening the baby that was growing in my wife's belly. Here they are, threatening the child that is growing in her belly, and, once the child was born, they threatened the child again, at birth. My wife, at that point, just couldn't take it any more.

At that point, I just couldn't—I mean, what could I do? I'm in a situation—I'm a stay-at-home dad. It's very hard to understand, because it's so non-traditional, that a man could be like the mother. I cook for the children, have dinner for them at 5 o'clock every single day when they come home from school or daycare. It's very hard for anybody to understand. They threatened the baby, and my wife just couldn't take it any more. She decided to settle in the case. We would never have settled in the case had they not started threatening. We've only had the experience with them for two and a half years. They've taken our children twice, and now they're threatening our newborn. Both myself and my wife, and particularly my wife—I would have just pursued it continuously, and I will not let go; but my wife—a newborn child; how could you have the child leave?

Let me just show you one other thing. I do have something that's very important. This is a thing that was given to us while we were at trial. We were at trial with the Family and Children's Services of Kitchener, and this was handed to us by a person like yourselves, who was concerned; just a regular person within the court.

The Chair: Yes, we'll pass it around.

Mr. Aneurin Ellis: If you read that, it's a little note telling my wife to not have the baby in the—that's the original note. I've photocopied that and blown it up. It's a note, coming from a person in the courtroom, just like yourselves. "Do not have your baby in the hospital. They will take the child away." Then she goes on to give my wife a phone number of a woman, a midwife, who will deliver the baby at home, and she also indicates on there, that it's top secret, "Do not even pass this information on to the lawyer," in particular the children's lawyer, from the office that a lot of people have a lot of complaints regarding. "Do not pass it on to that lawyer in particular," she indicates in there, and she indicates "top secret"; don't tell anybody.

Here's a person, just like yourselves—what is wrong when a person can't even stand up? There's something wrong with the system here, when someone who has

some decency and some ethics can't even stand up, and is terrified to do so. There's something wrong with that. She indicated there, "Don't tell anybody."

If we can reflect back to the 1930s in Germany: Out of that era, from the Second World War in Germany and the people who were involved in the Resistance, a lot of these people today are recognized as heroes. A lot of these people at that time were terrified to identify themselves or even say some things, but today they're recognized as heroes for saving many lives of Jewish people who were on the way to be executed. In this case, this lady has decided to give my wife this information and let her know that it's very important to keep it a secret. There's something wrong with that.

My concern is the complaints can sometimes take a long time, the court proceedings can sometimes take a long time, and the children need to be taken care of. The protection of the children has to be paramount, even if it is against the society. Thank you very much.

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The Chair: Thank you. There is about a minute and a half left—30 seconds for each party. Anyone has a question or comment, for 30 seconds only?

Ms. Horwath: You mentioned that you think that the section needs to be changed. Do you have any recommendation in that regard as specific?

Mr. Aneurin Ellis: I just feel that the complaints have to be addressed. If there's a complaint regarding the protection of a child, even this—my child is being abused by the society. I know this organization is in place—the child advocacy office and the court system—but in many cases, the families just do not have proper legal representation. We went through five lawyers. When we finally did get to a trial, we didn't have a lawyer at all. We had to represent ourselves. In some cases, this can happen. I just feel that it's very important that the act in itself has to protect the children, and it has to clearly identify the exploitation of children. How do you take a child and coerce her into saying something that was totally false, simply to create this—to almost create a diversion, or even to create a reason, justification or some type of legitimacy to the fraudulent apprehension?

The Chair: Thank you very much for your answer. Thank you for letting us know your story.

Mr. Aneurin Ellis: Thank you very much.

The Chair: Have a lovely balance of the day.

Interjections.

The Chair: The kids are watching themselves on TV; that's why they're all excited there. Thank you again.

Interjection: Bye-bye.

The Chair: Bye-bye. Thanks for coming. Thank you again; bye-bye. You'll be on TV shortly. If you want to know what time, ask the clerk, OK?

ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES

The Chair: Can we then move to the next one, which is the Ontario Association of Children's Aid Societies.

You have 15 minutes total, for presentation and all questions. Thank you. Sorry for the delay. We did ask for Mr. Ellis, but we had two of them. I didn't know that.

Ms. Kristina Reitmeier: It's no problem. Good afternoon. My name is Kristina Reitmeier, and I am chief counsel at the Children's Aid Society of Toronto. I'm honoured to address the committee, together with my colleague Dr. Nutter, on behalf of the Ontario Association of Children's Aid Societies, to which we refer as the OACAS.

The OACAS is an umbrella organization that represents 52 of the 53 children's aid societies in Ontario. I note that Ms. Jeanette Lewis, the executive director of the association, is present today as well.

The association is pleased to have this opportunity to address the committee and express the support of its member agencies for the general direction of Bill 210. We have also provided to you a written submission which we have prepared hoping that it would assist the committee not just in today's deliberations but also in the clause-by-clause a little later in this process. In our written submission, the association identifies specific provisions in Bill 210 that it supports and offers some suggested enhancements to other proposed provisions—enhancements which the OACAS membership believes will strengthen Ontario's child protection legislation to an even greater extent. We're not going to read our written submission today, but rather we'll address three particular areas of reform addressed in the bill.

As a CAS lawyer for more than 15 years, I have experienced the tremendous impact of the CFSA on child protection practice on the front line. The act governs all aspects of child welfare law, in both substance and in procedure. More importantly, it sets the tone and outlines the parameters within which we work. We are therefore very pleased that those parameters are being expanded to include a broader range of options for permanency for children.

In particular, we wish to express enthusiasm for the renewed emphasis on family and community that is evident in the bill. It starts with the expanded definitions of a child's extended family and the child's community, and it continues through provisions that will encourage placement with kith or kin as early as the first days following removal of a child from the parents, and always provided that an assessment has shown the placement to be safe. Under current legislation, it's not possible to place with family within that five-day window prior to the first court appearance that's required by law when a child is removed from family. Finally, this emphasis is evident in the provisions for making custody orders in the context of a protection proceeding. In all of these ways, Bill 210 emphasizes that children need families, and that these families and community placements require support.

I wanted to focus briefly on the custody orders. CASs have been challenged and at times quite frustrated by the narrow range of available options under the existing legislation. For example, currently, the only mechanisms

available for placing a child with extended family are, first, to make the child a CAS ward and the family or community member a provisional foster home. This option has the attendant intrusion by the worker and the lack of autonomy of the family, as there are regulations for foster homes, and workers need to visit and to document things frequently. A second option is to place the child with family under a supervision order, but this can be for a maximum period of 12 months at a time, requiring returning to court prior to expiry for a status review. The third available option currently requires that the family members bring a separate, second court application for custody against the parent under a different statute.

If Bill 210 is passed, it will permit the court, in appropriate cases, to make a custody order directly under the Child and Family Services Act right in the midst of a child protection proceeding after determining that a child cannot safely return home to a parent. Under Bill 210, custody orders would be available to those whom the child defines as his or her family or community. For a crown ward, this circle could include the foster parents. This, we feel, is a very good thing.

Overall, the amendments proposed in Bill 210 with regard to engagement of family and enabling family and community solutions support the clinical directions which the field believes are key to the transformation of child protection practice.

Dr. Brenda Nutter: Good afternoon. I appreciate the opportunity to speak with you briefly this afternoon, and I'd like to focus my comments with respect to most of the work in this legislation that pertains to adoption.

My name is Dr. Brenda Nutter. I've worked in child welfare for the last 36 years. I'm currently the resource supervisor at the Children's Aid Society of Northumberland, and have responsibility for both foster care and adoption programs. Over the past five years, I've been chair of the adoption task force of the Ontario Association of Children's Aid Societies, and also a member for three years of the CFSA committee. Today, I bring this accumulated knowledge and experience on behalf of the OACAS and in support of Bill 210.

I would like to make a few comments, but before so doing, I would like to draw your attention to page 3 of our written submission. That's where you'll find that there are nine statements that reflect inclusions in Bill 210 that collectively will create the opportunity for adoption to be a more effective path to permanency. We highly support this increased attention to permanency and to the changes that will provide the opportunity of adoption to children who under the current legislation would not be eligible for placement.

The openness provisions of Bill 210 combine the security of permanency within an adoptive family with the opportunity for a lifelong connection with the birth family. That connection might be as simple and as infrequent as a yearly letter or a gift at Christmas or on a birthday, but for some children it holds the promise of a real, lifetime connection to two supportive families who

work together to jointly support, encourage and enjoy a child whom they both love.

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For years, this type of openness has been available to children who have been placed through a private adoption system. Bill 210 will allow children who come into the care of children's aid societies to have the same opportunities when it is safe to do so.

Be assured that the OACAS is not under the illusion that fully open adoption is possible for all children. We do believe that, somewhere along a continuum of openness options, there will be a place for many children to have some sort of contact with their birth relatives, but not for all. That is why it is so significant that, under this legislation, a crown wardship order must be obtained before an openness order can be made. Openness has not been conceived as a bargaining tool to entice parents into consenting to crown wardship. Openness cannot be guaranteed. That said, we do heartily support the development of a practice that allows the greatest amount of openness appropriate to the circumstances, and we applaud the fact that the nature of the contact can be defined through either an order or an agreement. In addition, we strongly support the fact that, under the provisions of Bill 210, the failure to implement openness provisions does not make an adoption order invalid.

In conclusion, I'd like to say that we recognize that this legislation will require a substantial commitment by the government to the education of the public and of those in the field who will be charged with the implementation of Bill 210. It changes the face of public adoption. It is true that more children will receive better service through permanency initiatives. In addition, in-care costs will be reduced. But as this process moves ahead, it is important that the needs of adoptive families be recognized and fully supported as they manage the ever-changing needs of their older and special-needs children. In the public sector, we believe that the expansion of post-adoption services is a critical part of the infrastructure that will allow the openness provisions of Bill 210 to be successfully implemented.

In concluding my comments, I would just like to say that if I can answer any questions with respect to openness at the end of our discussion, I would be happy to. Thank you.

The Chair: We've got three minutes.

Ms. Reitmeier: I just wanted to address briefly a third area, and that relates to complaint and review processes under the act. The field recognizes that provisions regarding complaint review and complaint resolution are very important to the goals of accountability and transparency. They should not, however, result in delays for children such as the rest of the statute aims to reduce. That is why the OACAS feels it is important that there be timelines and clear expectations around the review of complaints. That's why the association suggests that duplication be avoided wherever possible, and you'll find in our written submission a suggestion that one review be available for a single circumstance, and not more than

one, so as to reduce delay. Similarly, where a matter is before the court, it should not be the subject of a review or a complaint process at the same time. That's a set-up for different decisions in different forums.

Complex and protracted processes create unconscionable delay for children and excessive costs, and that is why the field favours streamlining the complaint review procedures under the act. Because the complaints often involve clinical and practice issues, it is important that the ultimate reviewer have an appreciation for and experience in the field of child welfare.

Subject to any questions my friend and I would be pleased to answer, I would conclude here with thanks for listening to us.

The Chair: Thirty seconds each. Mrs. Jeffrey, you are next.

Mrs. Jeffrey: You've provided a really in-depth document. I've been trying to follow along, but it's hard, because you've provided so much detail.

I think you're the second delegate who has spoken to post-adoptive services for crown wards. Could you give me a little more detail than you've provided here? Is it just for special-needs children or the complexity of the children you're seeing that you recommend that?

Dr. Nutter: It's the complexity of the children, but it also speaks to the openness issue that this legislation brings to the fore. Once we have families who will be taking on children and also those children's families, we can anticipate that our adoptive families will need greater support in order to navigate through what that process will be like.

Mr. Ted Chudleigh (Halton): I'm wondering if the children's aid society, yours or any others—have you ever known them to conduct exit surveys with children who have grown up through the children's aid society and have reached adulthood and moved on? Do you go back and interview them as to what their experiences were, good, bad or indifferent?

Ms. Reitmeier: Many societies do that and are informed by that. Also, the ministry's crown ward review that takes place annually speaks to children as they go through the system and leave the system, and there's that feedback.

Mr. Chudleigh: All of them, or is it sporadic? How is that done?

Dr. Nutter: Societies often have exit interviews at the time that children leave care, but in terms of a longitudinal study that would look at what happens five or 10 years later, those are very infrequent.

Ms. Horwath: Thank you. I don't know if you were in the room earlier when we heard from some of our First Nations presenters, but one of the issues that came up was the extent to which children's aid societies are audited with regard to the success they have in meeting the needs of aboriginal children, particularly meeting their cultural needs. Are you aware if that occurs, if there are audits of children's aid societies to ensure that they are meeting the cultural needs of aboriginal children?

Dr. Nutter: I know that will come up when we're doing crown ward reviews, with respect to whether we're meeting the needs of children who have different cultures. That would be something that our crown ward reviewers would look for in our files, to ensure that we've taken some steps and, if it happens to be a First Nations child, have we connected that child with their First Nation and their culture?

The Chair: Thank you very much for your presentation.

DURHAM CHILDREN'S AID SOCIETY

The Chair: We'll move on to the children's aid society of Durham region. There are 15 minutes total that you can use for your presentation or a mix of your presentation and questions and comments.

Mr. James Dubray: Thank you, Mr. Chair. Good afternoon. My name is Jim Dubray. I'm the executive director of Durham Children's Aid Society. I'm in my 39th year of practice, and that's why I have a few of these little white things on my head.

Good afternoon, Kathleen. I haven't seen you for a while.

Ms. Wynne: Good afternoon.

Mr. Dubray: I wanted to go through our presentation and limit my concerns to issues around the openness in adoption, so I'll start there.

On behalf of the Durham Children's Aid Society, I want to thank the members of the standing committee for permitting us to make a brief presentation to you on the proposed legislation. We are supportive of the amendments to the Child and Family Services Act. Our association, the Ontario Association of Children's Aid Societies, has spoken today to their concerns on proposed changes, and we support our association in this endeavour. These changes, combined with other initiatives such as Healthy Babies, Healthy Children, Best Start and early learning centres, have the potential to establish a social safety net for children and families, a move that is long overdue in our Ontario.

Our intention today is to primarily focus on the potential implications of the Children's Law Reform Act on some of the proposed changes to the Child and Family Services Act. In addition, there are some other minor issues that we might propose to highlight for the committee itself.

This afternoon, we will be highlighting our concerns that are rooted in our agency experiences. In the past year, we have been piloting open adoption. Our experiences generally have not been positive. We have learned that in the making of and having agreements in place for adoption placement, the natural family sometimes have changed their minds with regard to the adoption placement and have sought to have it overturned by using the provisions of the Children's Law Reform Act. The Superior Court justice has agreed to hear the matter in September and is currently deliberating and deferring her decision on which act has primacy.

If the justice rules that the application has merit and can proceed, there is a good chance that the adoption placement can be overturned using the provisions of the Children's Law Reform Act. Needless to say, other counsel are watching this process very carefully, and if a door is opened to allow provisions of the Child and Family Services Act to be assailed by another piece of provincial legislation, we may find ourselves in a bit of a legal quagmire with respect to child protection and adoption proceedings. Our purpose today is to highlight for you those sections where you may want to further review the provisions to make it clear that the Children's Law Reform Act cannot be used to overturn rulings made under the Child and Family Services Act.

1730

We are certain that you are aware of how intricate and complex family matters can be. Emotions are strong, and when family issues are being discussed, and in some cases disputed, that is even more highlighted. Given that context, we want to appeal to you not to complicate these situations further by having these matters heard under two pieces of legislation.

The following are some of the examples to which we are referring.

Article 59.1 talks about the review of an access order made concurrently with a custody order. What this section seems to be contemplating is that if a person is not happy with a ruling under the Child and Family Services Act, then it is permissible, and in fact encouraged, for them to seek a further ruling under the Children's Law Reform Act. We would like to have family matters that originate in child protection settled under the Child and Family Services Act alone. Leaving another avenue of review is only going to prolong the family's angst and increase their costs. Would it not be better to simply state that such provisions under this legislation have primacy over the Children's Law Reform Act?

Article 65.1(9), no review if a child is placed for adoption: This agency supports the intention of this section. However, because of our experience locally where a family member has made an application under the Children's Law Reform Act to have its provisions trump the articles in the Child and Family Services Act, we are suggesting that a clause be added to this section that would prevent the Children's Law Reform Act from being applied to this section.

Article 65.2(6), custody proceeding: Our concern in this section is the same as articulated above. The article permits a justice to rule that an applicant has leave to proceed under the Children's Law Reform Act, and we believe that this should not occur.

Article 145.1(3)(c), openness order: The ministry is very courageous, I believe, in sponsoring openness in adoption in this legislation. You've heard earlier testimony today of how it can really benefit a child. However, human nature being what it is, any legislation must anticipate and regulate most anticipated uses of the legislation. With this in mind, we want to make some

generic comments that may help to promote a further refinement of these amendments that are being proposed.

As noted earlier, Durham Children's Aid Society has had a bit of a negative experience with open adoption wherein the grandparent of the adopted child is requesting, through the Children's Law Reform Act, that the adoption placement be overturned. We have mentioned previously that there needs to be a strong signal in the legislation that child protection and adoption matters are not subject to review by the Children's Law Reform Act. Currently, there is no strong signal to stop such action being taken.

In our review of the proposed revisions to the Child and Family Services Act, we have noted two additional concerns that we would like to bring to your attention. They are as follows:

Article 59(2), termination of access to a crown ward: We wanted just to highlight to the committee that the wording in sections 59(2) and 59(2.1) seems to be at odds: 59(2) seems to state that "any order for access made under this part with respect to the child is terminated," while 59(2.1) goes on to talk about the access orders and their different variations. In our view, the two things don't seem to jibe. Given the close connection of the sections, there seems to be some disconnection between their intent. Perhaps it is intended to mean something different than what it states, but we would ask that you further review it and ensure that what is meant is being said.

Article 59(4), society may permit contact or communication: The Durham Children's Aid Society thinks this section could be improved if there were a further sentence in that section that talks about "terms and conditions for contact and communication need to be agreed upon by the society in advance," much like is currently in article 153.6. So there is a further provision that you have around these issues in the current amendments.

We believe that the transformation agenda and these legislative changes are fostering more positive working relationships with children and their families. One of the key benchmarks of positive working relationships is the ability to reach agreements in advance on how parties will conduct themselves in any relationship. Given that there is the potential for situations and emotions to change, a more rational resolution can be reached in court or in alternatives to court if there is an agreement in place initially.

On behalf of the agency and our clients, I want to express our gratitude to the standing committee for your time and patience this afternoon. Again, we applaud the changes that are being introduced by the legislation and we would hope that today we have prompted some further discussions toward the goal of improving service to Ontario's children and families.

The Chair: Thank you for your presentation. We have at least one minute each.

Ms. Horwath: One thing came up yesterday afternoon. There was a presentation from some young

women, a very powerful presentation. As children who had been through the crown ward process, they didn't feel that their own voices were ever heard, or no one ever talked to them about the situation. The workers talked to them and a number of different people were dealing with their issues, but nobody actually heard their voices. Do you have any comments on that or any suggestions?

Mr. Dubray: Yes. There are different ways. I think that different agencies may have different provisions for taking stock of what children are saying. In our particular agency, we have a provision that children who are either on extended care and maintenance or who have just graduated from the system also come back to sit on our board of directors. So we have a feedback loop back to the agency at the board level and we've found that this kind of provision helps us a lot in coming to an understanding of how children can be impacted.

Ms. Wynne: Thank you, Jim, for coming today. Two quick questions. First of all, on the open adoption, you're just putting a caution in place. You're not worried about the general direction. Is that accurate?

Mr. Dubray: No, I'm not having any concerns about the general direction whatsoever. I think our concern is that frustrated clients with agreements may seek redress under the Children's Law Reform Act, and I don't think that should be legitimized.

Ms. Wynne: OK. Then the second thing, quickly: As I read 59(2) and (2.1), (2) is when there's an order that has been put in place, and (2.1) is a step before that, where it puts some parameters in place for an order being put in place. Do you know what I mean? It's almost like (2.1) precedes (2), as I read it. I don't see them as mutually exclusive. I'm not a lawyer, so I will check that out, but could you comment on that?

Mr. Dubray: It just seemed to me, when I read it—and I went back to the legislation and tried to insert both sections there—the two things seemed to be saying something different. If I'm seeing it that way, others may as well.

Ms. Wynne: Yes, so maybe we need some clarification, but often in these things the sequence is out of order.

The Chair: Mr. Chudleigh, any comments?

Mr. Chudleigh: Thank you. I was pleased to listen to your presentation. It sounds like things have improved a bit. I was a crown ward personally for about three years. I think your organization is probably doing a little bit better job than it did in my day.

Mr. Dubray: Thank you.

The Chair: Thank you for your presentation

SECOND CHANCE FOR KIDS

The Chair: We'll move on to Second Chance for Kids, Terry and Sheila. Thank you for coming. You can start any time you're ready.

Ms. Sheila Volchert: Good afternoon, committee members, ladies and gentlemen. I'd also like to introduce Terry Hrankowski. I'm Sheila Volchert. We represent the

Second Chance for Kids organization from the Niagara Peninsula. Terry and I will be doing a joint presentation this afternoon.

Second Chance for Kids is a support group for grandparents and extended family members raising children, as well as grandparents who have been denied access to their grandchildren. Terry and I really appreciate this opportunity today to raise more awareness of our situations.

We support Bill 8, An Act to amend the Children's Law Reform Act, which requires parents and others with custody of children to refrain from unreasonably placing obstacles to personal relations between the children and their grandparents. In other words, grandparents will be given recognition in our courts.

We also support Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts. This would include openness in adoption, legal custody orders to permit relatives to care for children permanently, and a requirement for the court to consider relatives before an order placing a child in foster care.

Both of these bills have recently received second reading.

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Terry and his wife, Barb, have been raising their three grandchildren for the past three and a half years. My husband, Hermann, and I have been raising our two granddaughters for the past seven years, and they are now eight and nine years of age. Hermann died on October 18 of this year after a two-year illness, and I am now raising my grandchildren alone.

Terry and I are members of the newly formed steering committee of the Canadian Association of Retired Persons, known as CARP. This committee was initiated by Judy Cutler and Bill Gleberzon, co-directors of government and media relations. I am also a committee member of the Consumer and Advocates Reference Group with the Provincial Centre of Excellence for Child and Youth Mental Health, which is striving to make some necessary changes needed in Ontario regarding children and youth. This committee is funded by the Ministry of Children and Youth Services.

Some statistics that may interest everyone here today: Statistics Canada numbers for grandchildren being raised by extended families with no parents present are steadily increasing. In 2001, there were 17,000 children in Ontario and 57,000 in Canada being raised by grandparents; in 2002, just a year later, there were 20,000 in Ontario and 70,000 in Canada.

Mr. Terry Hrankowski: In 2001, we were instrumental in bringing our concerns to the attention of the local community services department, which, with its input, generated a resolution with recommendations that were submitted to the Niagara regional committee and council in April 2002. These recommendations were approved by the regional municipality of Niagara.

In June 2004, Sheila presented a delegation speech to the regional municipality of Niagara committee members

regarding grandparenting issues. As a result, the same 2002 recommendations were reintroduced at that time and subsequently approved by both committee and regional council on June 7 and June 17, 2004, respectively. These recommendations are as follows:

Supports to extended families caring for children:

(1) that the province of Ontario amend the Child and Family Services Act to recognize custodial care by extended family members as a legitimate intervention and that the related funding to support these care arrangements be made available;

(2) that the temporary care allowance rate pursuant to the Ontario Works Act be altered to reflect established rates for similar care by foster parents;

(3) that the province of Ontario be encouraged to consider legislative changes to permit open adoptions.

Ms. Volchert: As I mentioned earlier, we sincerely support Bill 210 and are pleased that it has obtained second reading.

The regional municipality of Niagara council endorsed the above recommendations for caregivers of children. The same recommendations were also supported by the board of Niagara region's family and children's services agency as well as the Ontario Association of Children's Aid Societies.

Mr. Hrankowski: June 10, 2002, regarding provincial policy on the national child benefit supplement, NCBS: resolution approved by regional municipality of Niagara council. It recommended that the NCBS be exempt as income for families in receipt of the temporary care allowance. Unfortunately, retired grandparents on fixed incomes, widowed and disabled grandparents raising their grandchildren qualify for the benefit, but in most cases this automatically disqualifies their grandchildren for much-needed medical benefits such as prescriptions, preventive and emergency dental, eyeglasses and other discretionary benefits through social assistance and employment opportunities, also known as Ontario Works. Other provinces have wisely declined clawback of this federal financial assistance.

Ms. Volchert: The temporary care allowance, TCA, also provides assistance for children in financial need while in the temporary care of an adult who does not have a legal obligation to support the child. It has been mentioned in many conversations that Ontario Works is not the appropriate funding agency for the temporary care allowance. It has been suggested that the Ministry of Children and Youth Services should be responsible for these children and payment given to their caregivers as such. In this way, it doesn't carry with it the stigma of being on welfare.

Presently, the TCA gives \$220 for the first child in the home and \$181 each month for each additional child. This equates to \$7.33 a day for the first child in the home and \$6.03 a day for additional children. In comparison, foster parents receive a daily allowance of between \$25 and \$40 per child or more, depending on the needs of the child or special-needs child etc., plus other amenities for the children in their care.

Grandparents raising grandchildren also have special needs and concerns. Most grandparents are retired, widowed or disabled and living on fixed government pensions. We feel that grandparents should receive parallel funding similar to what foster parents are receiving, as we are raising children when their biological parents cannot. Statistics have proven that in most cases being raised by grandparents is definitely in the best interests of children. They take on the care of their grandchildren out of love, concern for their well-being, to give them a sense of belonging and to keep families together.

At the present time they receive very limited help and often are depleting their retirement savings to provide for them. Many have spent their life savings on lawyers, attempting to gain permanent custody. Grandparents are also concerned about furthering their grandchildren's education, which will be an additional financial burden on the grandparents' limited resources.

We have often said that it would be more beneficial for our government to ensure our grandchildren are given the financial supports needed now, rather than having to financially support their grandparents in later years as a result of depleted savings.

Mr. Hrankowski: In March 2004 in Ontario, there were 3,223 temporary care assistance cases receiving social assistance on behalf of 4,351 children. In Niagara region alone there are 396 temporary care cases. In some homes, grandparents are raising two, three or even four grandchildren.

We feel that children being raised by grandparents and extended families are unfairly discriminated against. Kinship families need government's help immediately to ensure that our grandchildren are taken care of financially. Most of these children have had a rough start in life. Please assist us in making sure that these children have a better future.

Ms. Volchert: On a personal note, as mentioned earlier, I am now raising my two grandchildren alone and will soon have no health benefits for either of them: These are prescription drugs, dental, eyeglasses and other discretionary benefits. I have been told that I must apply for the orphan's benefit on their behalf, and this amount plus the national child benefit supplement will be clawed back from the temporary care allowance that they have been receiving thus far. Also, they will no longer be eligible for the back-to-school and winter clothing allowances, community start-up benefits and PRO-kids, Providing Recreational Opportunities for Kids, which is now offered in the Niagara area.

As I mentioned during a presentation speech on June 10, 2005, at CARP, my husband had expressed his desire not to have lifesaving measures taken. However, keeping him on life support would have the benefit for his grandchildren to continue receiving health coverage. As a result, during his final hours, when hospital staff asked me again if I wanted to put him on life support, I really had to struggle with that question. I decided to abide by his last wishes and he ultimately succumbed to his illness later that evening. It was a heart-wrenching decision, and

yet I had to choose what I felt was best for my beloved husband.

This situation has happened to many widows on fixed government incomes and their grandchildren do not have much-needed medical benefits. It would appear that these children are being discriminated against due to the death of their grandparent. Apparently, one cannot collect the temporary care allowance and the survivor benefit at the same time.

Our present government has indicated that they want to eliminate child poverty, and yet, in many grandparent-headed families in Ontario there is child poverty. I know of many families who contact their local food banks just to make ends meet.

Mr. Hrankowski: In closing, I would like to say that grandparents have always helped to care for their grandchildren. However, when parents are unable to look after their children and the grandparents assume the parental role, they are now involved full-time, raising children for the second time in their lives. This role is accepted even though it comes at a time in their lives when they should be able to enjoy the retirement they had planned for. We have now undertaken one of the most challenging, most rewarding, most widespread tasks facing grandparents today. We've raised our children; now, we're raising theirs. We're involved full-time.

We love our grandchildren dearly, but we were not prepared to set new goals, fill new roles and meet new needs. We've had to re-examine our skills and develop new ones. We've had to reinvent.

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Ms. Volchert: In general, the public is not aware of this new entity. We, as parenting grandparents, are reaching out now. We need to tell our stories. We need to be recognized, acknowledged, respected, understood and supported. We are, after all, playing a vital role in raising the next generation. We are speaking out for all Ontario children, not just Niagara area's children.

Thank you for listening. We welcome any questions that you may have.

The Chair: Thirty seconds each. Ms. Jeffrey?

Mrs. Jeffrey: You would please Kim Craitor, a member from Niagara, who has Bill 8, the Children's Law Reform Act. He supports grandparents.

Can you tell me, do you speak on behalf of CARP? You've mentioned CARP in here, the Canadian Association of Retired Persons. Is this an amendment or a recommendation of that organization?

Ms. Volchert: No. CARP actually have joined our ranks. They are advocating for us 100%.

Mrs. Jeffrey: So they do support the legislation.

Ms. Volchert: Yes.

Ms. Horwath: Can I just ask, is there anything, in your review of the bill, that you would like to see changed specifically?

Ms. Volchert: Bill 210? No, we're just thrilled that there is the openness for what we would like to see, and we've heard so many in discussions: Young couples who aren't able to have children perhaps could adopt, say, our

grandchildren, and then the grandparents would still have that involvement. They would never lose sight of their own grandchildren. A lot of grandparents just aren't able to raise their grandchildren, for health reasons or whatever. They just can't do it. But they would love to still have that involvement.

The Chair: Thank you very much for your presentation.

ANISHINAABE ABINOOJII FAMILY SERVICES

The Chair: At this time, we have Mr. Marin, but I understand there is agreement with all three groups to allow, for up to five minutes, Ms. Theresa Stevens. Could we hear from Ms. Stevens now, please, for up to five minutes, and then we'll get to—

Interjection.

The Chair: It has been agreed by the three parties already: Ms. Jeffrey, Mr. Chudleigh and Ms. Horwath. Unless there is a motion on the floor—you can proceed, please.

Ms. Theresa Stevens: Thank you. My name is Theresa Stevens. I'm the executive director at Anishinaabe Abinoojii Family Services in Kenora, Ontario. I want to thank the committee for the opportunity to present. My sacred name is Menobagizhimoong and my clan is Kiishkamanizii.

I do want to preface my comments by saying I am Anishinabe Cree, and our traditional role is the care of children. I am an experienced aboriginal child welfare practitioner. That's where I'm coming from in relation to my comments. I support the position of the leadership from treaty 3. Their comments aren't meant to be seen as negating the need to still consult with First Nations. I am making commentary in terms of being a technician. I see this current system as only an interim arrangement on our way to the development of our own law.

Historically, child welfare reforms do not bode well for First Nations children, families and communities. First Nations were not consulted during the last round of the reforms, and those that managed to present to panels were told that First Nations issues were beyond the scope of the panel or committee's mandate and needed to be addressed in another forum. We are still waiting for a special forum to deal specifically with First Nations issues in child welfare.

When the ministry decided to conduct a review of aboriginal agencies, they never released the report publicly, so we do not know if there were any recommendations that would have benefited our communities and what those recommendations were. Even in the child welfare program evaluation conducted by Lucille Roch, it was strongly encouraged that there be increased recognition of the Indian/native provisions in the act. There were no recommendations to ensure compliance by ministries and agencies with those provisions, and in the one area where there was some autonomy for First Nations, they recommended legislative changes to give those

powers to the Lieutenant Governor. In this round of reforms, aboriginal representation in the Child Welfare Secretariat team occurred a year and a half after the process started. It was like we were an afterthought.

First Nations consultation takes place after the reform or policy has already been decided, when our leadership and technicians should have been part, right from the beginning, of the design and the development of those reforms and policies that have a direct impact on our children, families and communities. The government continues to make the mistake of assuming, when they consult with us as technicians, that they're consulting with First Nations leadership.

So what has been the result of the last round of reforms for First Nations children when we talk about outcomes and report cards? We have more children in care now, as Larry Jourdain mentioned, than during the height of the residential school era. Our numbers are disproportionately higher: 17% of those children in care. One of the reasons our number is higher is because the inclusion of chronic neglect and families with multi-complex problems such as domestic violence are now in the eligibility spectrum. This is in great part due to our socio-economic conditions, as well as the impact of the residential school program, over which our families, children and communities have little control.

Just as with the last round of reforms, the government continues to make the mistake of thinking they can apply one standardized approach for the whole province. Not all of the reforms and policy changes are negative, and we want some of the same things for our children. We too want better outcomes for our children. We want our children to know who they are and where they come from. We want them to maintain meaningful connections with their families, clans and communities. We want our children to have the same access to services that other children in the province have in order to be healthy and happy. We want our children to grow up to be successful and finish high school and go on to college and university.

We have practised a place of safety for our children through safe home declarations for a number of years now. We believe and practise placement priority, which stipulates that if children are not able to stay with their parents, we would first consider extended family and community members and other First Nations community members before we would consider a placement outside of the community with a non-native family.

We also practise least-intrusive, which means that if there is any way we can keep children from coming into care while ensuring safety, we are obligated to do so, as mandated by our communities. We use court as a last resort; in fact, the two Treaty 3 agencies have the lowest court costs in Ontario.

We are also mandated by our communities to work with families by bringing together extended family, interested community members, service providers, family service committee members, elders and agency workers in similar forums that are now being proposed, like

talking circles, family group conferencing and alternative dispute resolution. We too have struggled with wanting to find ways to include the child's counsel in order to maintain voluntary customary care placements, so these legislative changes will not radically change our practice or philosophy. We are already doing them.

The development of best practice guidelines for independence planning is a positive move. First Nations children have unique needs in this regard. How can we best transition our young people back to their community, and how best to ensure they have the resources they need at the community level in order to continue to grow and develop, to be healthy, happy and successful young adults who become contributing members of their community? Of course, we would welcome extension of extended care and maintenance in order to more firmly establish our young people, and to be able to provide it under customary care is a welcome change.

In the area of prevention, providing resources to prevent children from coming into care is a good investment, as is the flexibility to respond to families when they're in a financial crisis in order to keep children from coming into care. Families shouldn't be penalized financially for trying to help their own.

We too believe in prevention and early intervention, but these reforms and policy changes should not allow agencies to off-load their protection clients on prevention. Prevention and other community services need to be adequately resourced to take on an increased demand for services through deferential response.

Kinship care: There is a concern by First Nations that the intent of the expansion of kinship care is to erode or replace customary care. Having said that, more flexibility in licensing of foster homes is a good thing. It will encourage more aboriginal family and community members to take care of their own. The CAS will no longer be seen as being overly intrusive and bureaucratic when families are interested in caring for family members.

In the area of customary care, the First Nations we represent are against giving the Lieutenant Governor the authority to set regulations and standards for customary care. Customary care is a First Nations model of caring for our own. The government has no right to define them for First Nations. The aboriginal agencies which provide service to them are afraid that the intent is to erode the practice of customary care, and the setting of best practice guidelines is only the beginning.

1800

Foster care: Foster parents are being better resourced and supported to care for children, whether it be through adoption or legal custody, which is also a positive thing. This will encourage First Nation families who would like to assist relatives, but do not have the resources, to meet the needs of some high-risk, high-needs children and youth, as long as foster parents going for custody do not bypass the community and the band's party status in those proceedings.

This is my last point: It is not a given that all foster families will maintain access to communities for reasons

of culture and identity. This is why access orders enforcing compliance is important. Further, any training or curriculum developed for foster parents needs to be adapted for First Nation agencies and workers.

For example, the pride curriculum needs to have input from the elders of the Nations that is incorporated into the curriculum. Looking after children would be another example where aboriginal-specific developmental needs would be incorporated into the assessment, which is region-specific.

In order for these reforms and policy changes to be successful, there needs to be a corresponding investment in capacity and infrastructure building at the community level. This is greatly needed, as most First Nations do not have services that are available to mainstream agencies, such as children's mental health services and child developmental services.

Again, I thank the committee for the opportunity to present.

The Chair: Thank you, Ms. Stevens. I know you wanted to speak to us. Thank you very much.

OMBUDSMAN ONTARIO

The Chair: We will move to the last presentation for the day, a presentation from Mr. André Marin. I believe there's half an hour allocated for your presentation. Thank you. You can start any time you wish.

Mr. André Marin: It's an honour to be here this evening. I'd like to introduce as well Wendy Ray, to my right, who is the senior counsel in our office. I plan to make a short presentation and to open up to some questions.

As this committee knows full well, Bill 210 is not without its fair share of controversy. However, the objection I bring for your consideration is one that has not been heard publicly and one which I believe I am duty-bound to raise. In a nutshell, whereas other provinces have seen fit to provide independent oversight over their respective child protection agencies, the Ombudsman's office has, in Ontario, an extremely narrow opening to investigate complaints about the services sought or received by the children's aid societies.

That small window will close once this bill passes, unless this committee makes its voice heard. If that small window closes, Ontario will have the dubious distinction of having solidified its position as being at the back of the oversight pack in Canada in ensuring that the most vulnerable of our children have an independent avenue of redress.

We all know who the most vulnerable citizens are: children at risk, children whose parents are unable or unwilling to care for them. The importance of ensuring that we succeed in rescuing and protecting these children and in helping their families cannot be overestimated. After all, our children are our future. Today's children are tomorrow's citizens, tomorrow's parents, tomorrow's workers, tomorrow's governors. When today's children are protected and given a sense of self-worth, they can take care of tomorrow. But when things go wrong,

today's children can become tomorrow's burden. Worse, when things go wrong, today's children can be today's tragedies. When they are not given the effective support and protection that is their simple birthright as human beings, they are neglected, even abused. They are left unfed or unsupervised. At times, they are beaten or sexually violated, or in the horrifying case of Jeffrey Baldwin and his young sister, they can be denied their humanity entirely. As that case also shows, these tragedies can happen under our watch.

Fortunately, Ontario is blessed with good citizens who are prepared to make the protection of children their life's calling. There are 53 independent non-profit organizations in this province, children's aid societies staffed by dedicated people who try to pick up the pieces when our children are being failed. Their work could not be more important. The effectiveness of what they do could not be more urgent. But as is true of all humans, these societies sometimes fail, and the systems we have put in place to help them sometimes fail as well. When this happens, families can be broken apart needlessly or children can be deprived of stable foster care or adoptions can fail or, at times, children can suffer continued abuse or even die, as Jeffrey Baldwin did.

Jeffrey slowly starved to death in 2002 at almost six years old. He was only 21 pounds and stood at only 37 inches. Evidence now being called at the trial of his grandparents, who are charged with first-degree murder, is that he was living in his own feces in his bedroom while his lungs were filled with pneumonia. He was "treated like a dog" and forced to eat in a corner and urinate and defecate on the floor. Sadly, according to media reports, the Catholic Children's Aid Society of Toronto not only did not prevent this horrifying situation from happening, but facilitated it. This CAS gave custody of Jeffrey and three of his siblings to these two accused murderers. One of the co-accused had been convicted years before of assault/bodily harm in the death of her baby, who suffered broken bones.

If honourable members wonder how in God's name the CAS, our child protection agency in Ontario, could ever facilitate providing custody to someone in these circumstances, you are not alone. We received a complaint in the last month about this case and were asked to investigate. We had to turn it down. We have no jurisdiction over the CAS. If Jeffrey had had the good fortune of being born in any other province in Canada, lingering questions about the role or complicity of the CAS in the death of Jeffrey could be probed. Alas, in Ontario we are forced to simply turn a blind eye and move on.

Jeffrey's case may be an extreme case, but it is not a unique one. Children can die as 25-day-old baby Jordan did in 2001 when he starved to death while his 19-year-old mother was supposedly being supervised, because CAS workers assumed staff at a community women's shelter would take care of things.

It is never time to stop trying to improve things. It is never time to stop making the system and the people who administer it as good as they can be.

Like any thinking citizen of this province, I am therefore pleased to see many of the improvements to our child care practices being taken in the Child and Family Services Statute Law Amendment Act, things like increasing the flexibility of dispositions to meet the needs of each child, making the system friendlier for adopting parents, and the attempts to reduce the expense and acrimony of litigation by encouraging mediation.

But I did not come here simply to applaud the act. I am here because the legislation will fail in reaching another of its underlying objectives, namely, strengthening the complaint procedure to provide higher standards of accountability for children's aid societies. Not only will Bill 210 fail to achieve this, it will make it worse.

Currently, my office cannot accept complaints directly about children's aid societies, even though we receive hundreds of complaints annually; last year we received 305. In the first six months of this fiscal year, we received 94. Because of limits on our mandate, we cannot address them. We have to tell affected individuals caught up in what are likely to be the most important events in their lives—struggles relating to the welfare of their children—that we cannot help.

Other provincial Ombudsmen are not so limited. In her 1991-92 annual report, my predecessor lamented that "all provincial Ombudsmen except for Ontario and Quebec have jurisdiction over children's aid societies or their equivalent." Meanwhile, last year Nova Scotia passed amendments to increase the relevant jurisdiction of its Ombudsman.

Quite evidently, there is no public policy reason why my office should not be dealing with CAS complaints. Other provincial Ombudsmen do. Indeed, as long ago as 1986, a Canadian Ombudsmen conference in Ottawa passed a resolution to give priority to the investigation of complaints made by or involving children.

1810

Our inability to consider CAS complaints is not because of any concrete policy choice or because of concern that it would be unsuitable to have an Ombudsman help achieve inexpensive and expeditious solutions to the litany of problems that arise. Our inability to provide oversight is an accident of history. It is because Ontario is the only province in Canada where children's aid societies, although publicly funded and provincially monitored, developed as private institutions, and, like other provincial Ombudsman, my office generally oversees only government agents. At present, this gives me only a sliver of responsibility to oversee what I will call directors' reviews that are undertaken under subsection 68(3) of the Child and Family Services Act. Directors' reviews occur rarely, where the ministry chooses to exercise its discretion to assign a director to review a CAS decision. Since the director is appointed by government I can examine the way he or she conducts the review, but not the underlying cause.

So what does Bill 210 do in an attempt to improve the handling of complaints? Not only is the Office of the

Ombudsman of Ontario not taken advantage of, it is totally ignored. Bill 210 removes the jurisdiction of the Ombudsman of Ontario over directors' decisions by abolishing directors' reviews under subsection 68(3). While other provinces are moving forward in lockstep to give their citizens the benefits of an expeditious, inexpensive, informal complaints procedure relating to some of the most important matters those citizens will ever face, we in Ontario are moving backwards. How, then, can the government present Bill 210 as legislation that will increase CAS accountability by improving the complaint procedures? We do not yet know the details because they will be housed in regulations. What we do know is that the Ombudsman of Ontario provides the ingredients necessary for effective oversight, expedition, informality and effectiveness.

As Bill 210 recognizes, with its call for increased mediation, not every problem requires formal adjudication. Most of the complaints we receive can be resolved quickly and inexpensively through timely intercession. Sometimes it happens because our impartiality enables us to see obvious solutions that the parties are too invested to see. At other times we serve as honest brokers.

For deeper and more intransigent problems, particularly when those problems are systemic, there must be an investigation and there must be credibility in reporting. The Ombudsman Act provides our office with the tools needed to find the facts, including the statutory power to demand production and, if necessary, compel testimony and conduct hearings. We have the track record to employ reason and exercise moral suasion to secure results.

An elaborate statute has been crafted to make this office effective at external oversight. That statute is called the Ombudsman Act. This office, which administers that statute, is not only in place, it is well established. Giving the Ombudsman of Ontario jurisdiction to oversee the work of children's aid societies will provide the most expert, expeditious, informal and effective form of oversight possible. This is why my predecessors have been calling for this power for more than 20 years. This can be achieved easily, without having to amend the Ombudsman Act and without setting any precedent, as I already have some authority relating to private contractors operating under the Ministry of Correctional Services Act. The solution can be achieved by adding a single provision to the Child and Family Services Statute Law Amendment Act to give the Ombudsman of Ontario authority over children's aid societies.

I would propose that Bill 210 be amended by adding the following provision: "Approved agencies designated as children's aid societies under subsection 15(2) shall be deemed to be governmental organizations for the purposes of the Ombudsman Act."

In the end, this should be done for the most compelling of reasons: for the children and their families. If this power had been given when my predecessors called

for it in an effort to correct a technical accident of history, much of the grief experienced by the parents of disabled children told about in my report *Between a Rock and a Hard Place* may have been avoided. Those parents were forced to give up their children to children's aid societies in order to secure residential care they could not afford. While the societies were supportive in most cases, some of the bureaucrats they dealt with were insensitive to the realities of the situation and subjected these families to humiliation and degradation without apparent appreciation that they were dealing with loving, capable parents. And I wonder what kind of contribution we could have made to improving the protection for the Jeffrey Baldwins and the Baby Jordans of the world.

The province of Ontario provides over \$1 billion to fund child protection services through 53 independent children's aid societies, yet fails to provide the checks and balances that would ensure that administrative decisions taken by these societies, which have life-and-death impact on children in need, be exposed to independent investigation.

If we as a province want to discharge our deep moral and legal responsibility by using private children's aid agencies to perform one of the most important functions of government, that is fine; for the most part, those societies have acquitted themselves well and we are in their debt. We must, however, do what we can to make sure that they operate as effectively and as fairly as possible. They do the groundwork, but in the end, the children of this province are our responsibility. Their well-being is under our watch. Tragically, at times, we know that their very lives can be lost under our watch. We can never let that happen because we have not been watching effectively, nor can we permit families and adopting parents to suffer needlessly because we have developed an incomplete and ineffective oversight system.

This office was devised to improve the quality of decisions affecting the lives of Ontario's citizens. This is my plea to make use of it where it is most required.

Thank you, Mr. Chair.

The Chair: Thank you for the presentation. We still have about 12 minutes left, four minutes each. I'll start with Mr. Leal.

Mr. Jeff Leal (Peterborough): Mr. Marin, thank you very much for your presentation. You indicated that your predecessors have been making this request for over 20 years? What has been the response over that 20 years? What's been the formal reply back to the Ombudsman's office on this issue?

Mr. Marin: I think there's little appetite for oversight unless a crisis happens. You know, ministers do their work in good faith. They rely on public servants to give them advice. Unfortunately, it's not very high on the list of public servants giving advice to ministers to propose oversight, because oversight means someone looking over their shoulder. It's not popular; it requires a champion of oversight.

I have worked very hard behind the scenes in the last few months. I met with the Minister of Children and

Youth Services. I met with senior public servants, one of whom is present in the room today. I met with the deputy minister. I get very polite acknowledgment of my position. No one appears to challenge it, but it requires political fortitude and it requires the ability of public servants to recognize the need and not wait for the crisis. Unfortunately, that's what has been lacking in the last 20 years.

Mr. Leal: Along those lines, over 20 years, governments of all political stripes have been in power. Has any correspondence gone from the various ministers of the day back to the Ombudsman's office, formal correspondence with regards to this particular issue?

Mr. Marin: Certainly. I have correspondence from the current minister as of July 21 right here. I don't have the rest here, but I'm sure there is correspondence, yes.

1820

Mr. Leal: Could that possibly be tabled?

Mr. Marin: Certainly.

Mr. Leal: One last question; I'll make it very quick. In your presentation, you indicated that 305 complaints have been made to your office regarding CAS. Do you have the resources to handle these complaints, to do a thorough job?

Mr. Marin: If we were extended the oversight of CASs, I assume there would have to be an adjustment in terms of the resources given our office. I don't have an exact number on that. But if you look at the Jeffrey Baldwin case, the media have called for a public inquiry; the last public inquiry cost in the tens of millions of dollars. Our annual budget is \$9 million to handle 23,000 complaints a year. So whatever the adjustment in our budget, it would be infinitesimal compared to the contributions we could make.

Mrs. Jeffrey: A quick question. It's my understanding that you have some statutory authority already. I understand you said that when you were doing MPAC, you had very robust investigative tools, and you could do informal interviews, seizing evidence, summoning witnesses and conducting public hearings.

Mr. Marin: Yes.

Mrs. Jeffrey: How would this change your ability to do what you're asking for now? I guess I was under the impression you had tools to provide those kinds of special reports, that because of your SORT team, you could go in and do the kind of work you're asking to do.

Mr. Marin: Because the CAS is outside our jurisdiction, we can't do anything with regard to any complaint about the CAS, contrary to every other province in this country. We can't. The tools are there, but because the CAS is private and not public—our legislation only gives us authority over provincial public institutions; it doesn't include the CAS. That's why we're proposing this amendment to you today.

Mr. Chudleigh: Are you saying that there's absolutely no oversight from any organization over children's aid societies?

Mr. Marin: That's correct. The act provides for an internal review process. The amendment to the act—

Mr. Chudleigh: From within the children's aid society.

Mr. Marin: That's within. There's no outside investigation of complaints about the CAS.

Mr. Chudleigh: But if there's a serious complaint, surely the police would have the authority to go in and to do an investigation.

Mr. Marin: A criminal investigation. With the Jeffrey Baldwin case, the allegation about the CAS is that administratively they dropped the ball, not that they committed a criminal act, so the police will not investigate that.

Mr. Chudleigh: Under the municipal regulations for the municipal area, there's no organization, no branch of the municipal governments that would administer that, the health unit, for instance, or some other organizations? They don't have any responsibility for looking at children's aid society cases?

Mr. Marin: No.

Mr. Chudleigh: None whatsoever?

Mr. Marin: None.

Ms. Horwath: It's interesting, because in fact we had a presenter today who had a complaint about the CAS. I find it interesting that we're hearing from you at the end of this day, when we had someone who came to us this afternoon to actually highlight that very issue. He's been through the courts, with five different lawyers, trying to get some justice for the way he was treated by the CAS in his particular case.

I wanted to make the point, and I think it's an important one, just to add to the point you raised around the issue of costs, and the cost of inquiries versus the cost of perhaps an enhanced budget to oversee this particular area, let alone the costs that children or families would have to pay if they're not getting appropriate treatment

from the CASs. I'm very pleased that you've brought this forward. I think it's an extremely important issue.

I wanted to ask if, in your opinion, this recommendation you've put forward could easily be put into legal language and submitted as an amendment to this bill. Is that something you would see as being—

Mr. Marin: Absolutely, and we provided you the legal wording in the submission.

Ms. Horwath: So the language on page 4 is in fact the appropriate language to be added to the bill?

Mr. Marin: Yes, subject of course to what your legislative drafters would have to say, but it is appropriate legal language.

The issue here is, who will champion this? That's really the issue. I think this act generally does a lot of very good things. Over the last 20 years, we've had excellent ministers in charge of this file. The issue is not a political one. That's why I'm appealing to this committee to approach it on a non-partisan basis. The minister takes advice from his or her public servants; it's not popular for public servants to advocate oversight. When is the last time you heard a public servant ask for increased oversight in their area? They'll do it, as they're doing it in Ottawa after a royal commission costing \$100 million, when there's an election on their heels. I think it would assist the minister to know that there are champions in the form of this committee who are prepared to step up to the plate for the children.

The Chair: Thanks very much. I think it's very clear. We thank you for coming and giving us your view on the matter. Enjoy the balance of the evening, all of you.

At this time, we will adjourn the meeting. We will reconvene on Monday, December 12, at 3:30 or so in this room. Thank you again.

The committee adjourned at 1825.

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**Legislative Assembly
of Ontario**
Second Session, 38th Parliament

**Assemblée législative
de l'Ontario**
Deuxième session, 38^e législature

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(Hansard)**

Monday 12 December 2005

**Journal
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Lundi 12 décembre 2005

**Standing committee on
social policy**

**Child and Family Services
Statute Law
Amendment Act, 2005**

**Comité permanent de
la politique sociale**

**Loi de 2005 modifiant des lois
en ce qui concerne les services
à l'enfance et à la famille**

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 12 December 2005

Lundi 12 décembre 2005

*The committee met at 1622 in committee room 151.*CHILD AND FAMILY SERVICES
STATUTE LAW AMENDMENT ACT, 2005LOI DE 2005 MODIFIANT DES LOIS
EN CE QUI CONCERNE LES SERVICES
À L'ENFANCE ET À LA FAMILLE

Consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts / Projet de loi 210, Loi modifiant la Loi sur les services à l'enfance et à la famille et apportant des modifications complémentaires à d'autres lois.

The Chair (Mr. Mario G. Racco): Good afternoon again, and thanks for waiting for us. We had to deal with the votes upstairs, but now we are here. I want to make sure everybody is aware that there are four presentations right now. Some of you have only two on your agenda. Two other people did attend, as you remember. We were open-minded that the people who showed interest prior, if they would notify us, we would allow them to speak if time allowed. Since we had only two on the agenda, we added two more, so we have four. In fact, there is space for additional people if they do attend.

ASSOCIATION OF IROQUOIS
AND ALLIED INDIANS

The Chair: We will start then with the first presentation this afternoon, and that is the Association of Iroquois and Allied Indians, Chris McCormick, Deputy Grand Chief. Thank you, Mr. McCormick, for waiting. We have 15 minutes for your presentation. If you don't use all the time, we will be able to leave it for questions or comments. You can start anytime.

Deputy Grand Chief Chris McCormick: I was wondering, Mr. Chairman, if you could give me an indication of when I'm around the 10-minute mark.

The Chair: Yes, when you've used 10 minutes, so you'll have five to go. I'll do that.

Deputy Grand Chief McCormick: I'd just like to acknowledge the committee and the work that you're about to do and to wish you every success.

The Association of Iroquois and Allied Indians is a political organization. We represent eight member First Nations. We have an approximate population of 20,000

people. To put this in perspective, I just need to ask if any of the committee members have ever lived on a reserve?

The Chair: Have any?

Interjection.

The Chair: Ms. Wynne has.

Deputy Grand Chief McCormick: Then I think it's important to put this in perspective. Because we're a tribal people, in a First Nation, for the child, both sides of her parents live there, her mother and father, her brothers and sisters, her aunts and uncles from both sides of her parents, her nephews and nieces, her grandparents, everybody who's important to that child in her life lives in that community. I think that's important for you to understand when we're talking about First Nations and their relationship to the amendments to the bill.

I wanted to point out a few statistics: 30% to 40% of children in care in Canada are aboriginal. This is from the INAC study. According to the United Nations human development report, Canada rates fifth and First Nations rate 63rd. According to the minister's statistics in our meeting with her the other day, 17% of the 9,000 children in care in Ontario are First Nation children, and First Nation children make up only 2% of the population in Ontario. So there's a big problem with First Nation people and the apprehension of our children.

Part of this problem has developed because the government has failed to meet its obligation to consult with First Nations. In regard to consultation, there is a political, legislative and legal obligation to consult with First Nations. The Prime Minister recently made promises to the five national aboriginal leaders that no longer would they be presenting legislation without consultation with First Nations. Premier McGuinty also promised First Nations that there would be consultation. Legally, the Supreme Court's decisions and the Constitution, section 35, say that aboriginal treaty rights are recognized and affirmed. Customary care is an aboriginal right. It's also an international human right that people can look after their own children.

Legislatively, you have the 1965 welfare agreement, which states that there has to be consultation with the province or with the province and the federal government with the agreement of First Nations before there are amendments regarding their constitutional aboriginal rights.

There was only a short period of time in which the ministry invited comments, from January 21 to 31. It was

on their Web site. That's not considered consultation, as far as I know. We did have a Chiefs of Ontario resolution in 2004, which was passed on to the minister, requesting a separate consultation process.

Section 2.2 of the Indian welfare agreement states, "No provincial welfare program shall be extended to any Indian band in the province unless that band has been consulted by or jointly by Canada and by Ontario and signified its concurrence." That has not happened. The purpose of 2.2 was to ensure First Nations had control over programs that are extended to them.

The welfare agreement also provides that the level of services will be comparable to the rest of Ontario. The services that we have are not comparable to the rest of Ontario. We want to point out that the 1965 welfare agreement is cost-sharing and open-ended. The minister has the prerogative to act if First Nations services aren't comparable to Ontario; past ministers have not. A glaring example is the discontinuation of the band rep, who was the representative of the community in court cases where children were being reviewed for apprehension. We are hoping that this minister will see fit to exercise her authority and jurisdiction.

There's also the legal obligation under Ontario law that the act be reviewed. For there to be a proper review, there should be consultation with the people who are affected under section 10, which pertains to aboriginal people. There was no formal consultation with our First Nation people.

Bill 210: Section 44, amending section 223 of the act, proposes that the Lieutenant Governor of Ontario have the power to make regulations pertaining to "(c) governing procedures, practices and standards for customary care." This is in conflict with the current definition which states that customary care means the care and supervision of Indian or native children by a person who is not the children's parent according to the custom of the child's band or native community.

This is the point: Customary care is deeply rooted in First Nation culture. It is an aboriginal and treaty right and therefore it is supported by the Constitution. First Nations maintain that the finding of customary care rests with each individual community. For example, I might point out that there's as much assimilation between an Ojibway and an Oneida as there is between a Swede and a Norwegian. So again, it's in perspective with what a First Nation community is about.

1630

A recommendation: Part X of the Child and Family Services Act includes section 212, "Subsidy for customary care," which states that "a society or agency may grant a subsidy for the person caring for a child." Not paying a subsidy has led to placement of First Nations people in non-cultural, non-Native families. The word "may" should be removed and replaced with "shall" or "will," and a full subsidy equal to the current foster care rate should be granted, not a partial subsidy through Ontario Works. Part X has been in place for 20 years. It's part X that must be fully implemented and dealt upon.

With us, we would hope that it would lead to a First Nations welfare act.

The band representative—we mentioned that. It was a crucial link between the children, the children's aid society and Family Courts. It was discontinued in 2002, and that's the reason the minister is telling us that 17% of the 9,000 children in care are First Nations children. The discontinuation of that program has had a dramatic effect on First Nation children. The 1965 welfare agreement provides for equity of services comparable to Ontario.

The Association of Iroquois and Allied Indians statement on customary care:

It takes a whole community to raise a child. In order to ensure long-term, positive social, emotional, physical and spiritual development of our children, it is imperative that a child in need of protection is placed with their extended family or community in a customary care arrangement, as practised by the individual community.

In order for First Nation children to succeed and reach their full potential, we must develop programs and services that are rooted in the First Nations culture, language and customs, and meet the specific needs of our communities.

In order for there to be a true and significant change to the dismal numbers of child protection issues within our communities, First Nations need to be full partners and take a lead role in child welfare reform that occurs in Ontario.

With this being said, we are asking the legislative committee to consider the following:

(1) That section 44, subsection 223(c) of Bill 210 be removed from the act.

(2) The Association of Iroquois and Allied Indians expects the Ministry of Children and Youth Services to respect the wishes of First Nations that a separate consultation process be developed for First Nations to review and provide recommendations.

(3) The Association of Iroquois and Allied Indians is asking the Minister of Children and Youth Services to exercise her authority under the 1965 Indian welfare agreement to appropriately fund child welfare programs on reserve.

(4) The Association of Iroquois and Allied Indians is also asking for the support of the minister in the development of a First Nation child welfare act.

I'd like to leave it there and to answer any questions that any of the committee members may have.

The Chair: Thank you. There are about four minutes left, and we'll give about a minute and a half each. Should I start with you, Madam Munro, please?

Mrs. Julia Munro (York North): All right. Thank you very much for coming today and providing this for us to give consideration to. I wondered if you would speak to a couple of the issues that you have referenced at the back. Particularly, I'm interested in issues around the openness orders and the alternative dispute resolution. As you've defined the part in the current bill that says that the openness orders are meant to facilitate communication or maintain a relationship etc., I just

wondered if you wanted to comment on (a) the appropriateness of openness orders, and (b) the way in which you would wish that idea to be put forth in an amendment.

Deputy Grand Chief McCormick: I guess to try to put it in perspective, there may be a problem in the child's community, but as we pointed out, the child's extended family exists in the community. The ability to be taught our language, to be taught our traditional dance, to know the history of our community and those perspectives that are important to our life need to be a component of this openness. Presently, there isn't that avenue there, where the community is going to have access to that child, and that's what is important.

The overall, long-term objective of the province of Ontario, which we agree to and support, is an Ontario where all children have the opportunity to succeed and reach their full potential. For that child to receive its full potential, the person has to know who they are, what their history is, what their language is. That's when they will reach their full potential.

The Chair: Thank you very much. Ms. Horwath, please.

Ms. Andrea Horwath (Hamilton East): I'm glad that I got a chance to get in while you were still talking. I'm sorry I was a few minutes late.

I wanted to ask you about your comments around two pieces. One is the lack of equal services for First Nations children, as well as the issue of funding. If you could just expand on those two issues a little bit, I would appreciate that.

Deputy Grand Chief McCormick: We've mentioned that the department cut services to the band rep. A scenario is, if you go to court, the child has a lawyer, the parents have a lawyer, the CAS has a lawyer, but the band doesn't have a lawyer. That's an example where there isn't equitable funding. It's a component where the minister has the prerogative under the 1965 welfare agreement to make sure that services are comparable to Ontario's. I think that's an example that could be used to answer your question.

The presenter after me is going to more fully answer your question, in particular to the First Nation of Tyendinaga. You'll get a full, comprehensive review of the services that aren't being provided for presently by the minister.

I just wanted to point out that some First Nations are presently paying for a band rep under the monies that they're getting from Casino Rama. My response to that is that you have an act that deals with children. That act has got to be able to stand on its own. It shouldn't have to borrow from monies that First Nations people get from Casino Rama to pay for a band rep to represent their child and themselves in the court. If you want a good act, it's got to stand on its own.

The Chair: Thank you, Ms. Horwath. Mr. Ramal?

Mr. Khalil Ramal (London-Fanshawe): Thank you for coming today. I had a chance to meet with your group three weeks ago. I learned a lot about your issues. We

also heard from various native groups that came before this committee and spoke about customary care. Do you have any communication with other groups in order to establish some kind of method you're looking for in terms of customary care? We heard about different styles. Is there anything like a style proposed by all the native communities across the province?

Deputy Grand Chief McCormick: That would be hard to accomplish. For example, I'll use the Oneida and Ojibway. Oneida is a matriarchal society, Ojibway is patriarchal, so there is a distinct difference there. The languages are different. The history of the community and people is different. The way they dance is different. So what they develop in the community of Batchewana, which is Ojibway, they wouldn't even think about trying to say to the Mohawk people of Tyendinaga, "This is the way you should have your customary care." That's why the position of the association is that that responsibility to define what's good for their children or community rests with the chief and council and the people of that community.

Mr. Ramal: These details—we're talking about the concept, the method, the way we have to deal as the law rules should be applied across the province the same, with provision for native communities. I'm not talking about how you implement on the ground, whether a matriarchal society or patriarchal society.

The Chair: Mr. McCormick, could you answer quickly, please? We're over time already.

Deputy Grand Chief McCormick: The method, I guess, would have to be in a consultation process, which we haven't had the opportunity to proceed with. We're just reacting to a bill that's been put on us. We've had a review of it, and we haven't had a chance to come forward with recommendations that might be reflective of what First Nations want.

The Chair: Thank you again for your presentation. We'll move on to the second presentation. I know there were some more questions, but we are over time.

Deputy Grand Chief McCormick: I would just like to thank you for giving us the opportunity to come here.

1640

MOHAWKS OF THE BAY OF QUINTE

The Chair: The Mohawks of the Bay of Quinte, Mr. Donald Maracle. Chief Maracle, you can start any time.

Chief Donald Maracle: *Remarks in Mohawk.* Good afternoon, everybody. Bonjour. I'm Don Maracle. I'm the Chief for the Mohawks of the Bay of Quinte, the fourth-largest First Nations in the province of Ontario, the sixth-largest in Canada. I would first like to thank each and every one of you for the opportunity to address the standing committee on social policy on this most important piece of legislation, Bill 210.

As we approach the holiday season, the topic of children and their special place in our world is on everyone's minds. It is the season of joy and hope for the future. With this in mind, I feel this is a most opportune

time to address this committee on this most important topic.

A long-term goal of the Ontario government is to create "an Ontario where all children have the opportunity to succeed and reach their full potential." The Association of Iroquois and Allied Indians and the Mohawks of the Bay of Quinte fully support this goal and we are committed to working in partnership with the Ontario government to achieve the goal for our First Nations children. In order for First Nations children to succeed and reach their full potential, we must develop programs and services that are rooted in First Nations culture, language, customs and tradition, and that meet the specific needs of our communities.

There is the appearance that the ministry is readying itself at an operational level for quick passage of this bill and, as First Nations communities, we find this insulting and very inappropriate.

My presentation will highlight three key issues that the Mohawks of the Bay of Quinte have with this bill in its present incarnation: (1) The obligation to consult with First Nations communities—this is protected in the 1965 welfare agreement and has been ignored; (2) jurisdiction as it relates to customary care—a one-size-fits-all approach is not acceptable or in keeping with any nation-to-nation recognition; (3) immediate action—First Nations do not have the luxury of time on these matters.

Firstly, there's an obligation to consult with First Nations in Ontario. The Prime Minister of Canada, the Right Honourable Paul Martin, made the following statement in his opening address at the Canada-Aboriginal Peoples Roundtable on April 19, 2004: "No longer will we in Ottawa develop policies first and discuss them with you later. The principle of collaboration will be the cornerstone of our new partnership." If it's Canada's model, we wonder why it's not Ontario's.

The Premier of Ontario, Dalton McGuinty, has also committed to a new relationship with Ontario's Aboriginal people. He has committed to "build a brighter future for aboriginal children and youth" in partnership with aboriginal people. Ontario, through its new approach to aboriginal affairs, has committed to meeting its duty to consult with aboriginal peoples where actions may adversely affect an established or asserted aboriginal or treaty right. Under the 1965 Canada-Ontario welfare agreement, the province is obligated to consult with First Nations about any social program changes covered in the agreement: child welfare, day care, welfare and home-making programs. Clause 2.2 of the 1965 Canada-Ontario welfare agreement states, "If and as First Nations agreed to accept these services as a result of consultation with the federal government, or through consultation with the federal and provincial representatives."

Review of the Child and Family Services Act: As a legal obligation, the minister must review the CFSA every five years. A review, as we understand it, must include complete and proper consultation, which did not occur. The public notice for input was very short—January 28, 2005, to March 31, 2005—and was via the ministry's Web site.

The Chiefs of Ontario, at a special assembly from November 9 to 11, 2004, in Thunder Bay, passed resolution 04/70, First Nation Child Welfare: 2005 Legislative Changes. The resolution called for a separate consultative process for First Nations to review and provide recommendations on any proposed legislative changes pertaining to child welfare. A First Nations process of consultation was not pursued by the Ministry of Children and Youth Services.

In the previous review of the Child and Family Services Act in 2000, the ministry failed to consult with First Nations. Sweeping changes to the CFSA were introduced and actually increased to a record number First Nations children being apprehended by children's aid societies. Some examples are:

—grounds for protection: 2000 CFSA changes introduced neglect as grounds for protection. This change increased apprehensions of First Nations children. The changes did not take into consideration existing socio-economic factors on reserves, such as housing shortages. It is common for two or more families to share a house. This was considered neglect by the children's aid society, and children would be apprehended.

—lowered threshold of risk: The language was changed in the 2000 amendment from "substantial" with regard to harm to a "likelihood" that the child would be harmed. Coupled with neglect as being grounds for protection, this increased the number of First Nations children involved with children's aid societies.

Jurisdiction, customary care: Section 44 of Bill 210, adding clause 233(c) to the CFSA, proposes to strip authority in the area of child welfare by giving the power to make regulations, policies and practices to the Ministry of Children and Youth Services. First Nations in Ontario have always maintained that the defining of "customary care" rests with each individual community, as nationality, customs and practices vary among First Nations. This is also supported by the current wording in the Child and Family Services Act. First Nations, as peoples, possess the human right to care for our children based on our customs, practices, traditions and culture.

There needs to be a First Nations-specific home study completed for customary and foster care. This needs to be done based on the principles of community and cultural respect. Currently in our community, Mohawks of the Bay of Quinte have no available foster homes for our children when they are taken into care of the children's aid society. They must leave their homes and, as a result, attend public schools off-reserve, where there is no Mohawk language for them. They are forced into French classes, but they have never had any previous French training.

If this bill passes without significant rewriting and a major overhaul, it will be another five years before any of this dialogue gets brought to the forefront. As First Nations, our issues are pressing, and another five years of inactivity is simply not acceptable.

We met recently with Minister Chambers and we all got the very real sense and commitment that proactive

change was needed and that the status quo was not going to cut it. Although we appreciate the need for a process, our programs and services continue to be overstretched and underfunded while the process unfolds. I cannot overemphasize that our needs are real and they are right now.

Funding levels: Our programs are funded using archaic formulas and have not increased in many, many years. Our needs continue to increase. More and more people are moving back into the territory. The impacts of Bill C-31 have been enormous. Our conditions are ever-changing and becoming more and more complicated, yet our funding remains stagnant in any real terms. Since the 1994-95 fiscal year, our funding from the ministry has increased by a total of 4%. This is unacceptable. Our funding is statistically 22% behind the mainstream. For every dollar mainstream family and child services receive, we receive 78 cents. How can this possibly be explained? The salaries of our professional employees lag behind any reasonable standard. Program money is exhausted quickly, program development desires are thwarted by a lack of funding, and yet we continue on as best as we can. We slide further and further behind and, at the grassroots level, we never see any real change or commitment.

Band representation: This is mandated in provincial legislation. It's a critically important component in the process, yet no funding exists for this mandated position. If band interests are to be brought forward at child protection proceedings, it cannot be done with legislative text. There needs to be a real commitment of resources so that the intent of the text can be operationalized. Our approach to the band representative is ad hoc at best. This only serves to confuse the clients, the judges and the court system. This in no way serves the interest of our children.

Adoptions: I am told that once a native child enters the system, after only 12 months can they be put up for adoption. It is measures like these that need to be addressed imminently. Our children are being lost and these arbitrary measures need to desist. Just waiting out the passage of the bill and no real action is not an option. Things are happening on the ground yesterday, today and tomorrow that need a logical, respectful and resourced approach.

1650

In closing, I would like to again state that in terms of Bill 210, the Mohawks of the Bay of Quinte are particularly concerned with the issues of obligation to consult under the requirements laid out in the 1965 welfare agreement and the entire gambit of customary care as it relates to mutual respect and appropriate funding. Nonetheless, I want to underscore my third point, that the time for action is now. Our funding is stagnant. There are short, quick fixes but there is no tangible change to the status quo in terms of funding. One thing has changed, though: Our need has changed. Society is becoming more and more complicated, and issues concerning children and families are becoming more and more difficult.

Without adequate resources, we continue to play catch-up, and we are never in a position to offer what we feel is needed in terms of support.

Please bring these important points forward as you continue to deliberate on this bill. We believe in a foundation of mutual respect and we have every confidence that you will see the amendments and approach that we seek.

Just to emphasize the point, a record number of First Nations children are currently in care in the province of Ontario, more even than before the 1960s scoop. The CFSA mandate is twofold: protection and prevention. It's the prevention component that's seriously underfunded. All of the funding seems to support protection, with very few resources for prevention programs. We believe that prevention programs will work best in our community before there is a need for a children's aid society to become involved with our children.

There is a chronic shortage of housing. If housing is the issue, people can be on a waiting list for several years before they can get a mortgage. The band in our community only builds 12 houses a year; that's what we have funding for. If they don't qualify for a bank loan, then there's going to be the housing issue. That doesn't reflect on the quality of parenting that the parents provide; it simply speaks to the community's lack of resources to address very basic needs.

The Chair: Thank you for your presentation. We have about a minute each. Ms. Horwath, you're the first..

Ms. Horwath: Thank you so much for taking the time to come in and enlighten us with your experience as to how this bill has come about and how it has been raised with you as a community. You mentioned in your presentation—and I thank you for it; it's very detailed—that you had an opportunity to meet with the minister already. Did you get a sense that she's prepared to deal with some of the issues that you raised, or do you get a sense that she's more prepared to just ram the bill forward and not address your concerns?

Chief Maracle: The sense I get is, first of all, that the minister is committed to a specific First Nations child welfare act, which we do support. There is something similar to that in the United States. Our socio-economic circumstances are much different than Ontario's. As a matter of fact, the Canadian government now has a policy of allocating \$5.1 billion to close the gap between the standard of living of First Nations people and other Canadians. The national government recognizes that the quality of life in First Nations communities is less than the Canadian norm, and that's the kind of environment in which our children grew up. I grew up in a very poor family, but I had a very good mother and a very good grandmother and good uncles and aunts who all shared in the rearing of the children. The whole family pitched in, because we are a traditional society; that's what we do.

The other sense I get from Minister Chambers is that the plight of First Nations children is a very serious matter that she takes seriously, and she wants to see improvements made so there are not so many children being apprehended and taken into care.

Mrs. Linda Jeffrey (Brampton Centre): Chief Maracle, it's nice to see you again. You spoke eloquently the day you met with Minister Chambers. I was lucky enough to be in the room while you spoke. I was very impressed with your comments that day.

I was surprised by what you said in your presentation about the discussion we're having today on the bill being, because of its quickness, insulting and inappropriate. Then in the next paragraph, you talk about how we need immediate action. I guess I just want to say that when I heard Minister Chambers speak, she did talk about the need for taking care of children, that we needed to act quickly and that it's really important. That was the message I got that day, as you've mentioned today: that you don't have time, that there are children who need protection now and that we need to put amendments in place that will protect those children. It's important.

You didn't speak about customary care. Do you have concerns about the legislation and customary care? You didn't mention it in this deputation.

Chief Maracle: Customary care has to be defined by our own people, by the standards of our own First Nation. The people who live in our community know our people the best and the people who provide and render services tend to know who's best to give customary care, as opposed to the local children's aid society, which may not know anybody there. Fortunately enough, we have Christine Claus here, to my left, who is our representative on the Hastings Children's Aid Society, but many First Nations do not have any representation on the children's aid societies that serve their communities, so you have people making very serious decisions about the children who don't know any of the circumstances of the families. Sometimes they tend to be very judgmental, in a very inappropriate way. I think the decisions need to be made in the community.

If resources are going to be allocated for customary care, then those resources should be managed by the First Nations community government as part of our move toward self-determination. If they're given to the children's aid societies—most of you know they have been chronically underfunded and have had to come to the government for bailout funds to clear up their deficits. Usually, the board will prioritize many things, including their own salaries. We want customary care to benefit the children that need it in our community.

Mrs. Munro: Thank you very much for coming today. I want to ask you a question related to what is obviously a very complex issue in terms of customary care. You mentioned in the response a few moments ago about looking at other jurisdictions, and I wondered if you had any opportunities to see best practices in the area of defining customary care and the kinds of things that you would want to see included in those potential changes.

Chief Maracle: In terms of customary care, it has to deal with the person as a whole person. It has to look at their basic needs for food, shelter and clothing and to be sent to school and those sorts of things, but it also has to

develop their spirituality and intellect to make them a well-rounded citizen. The only way they're going to achieve that is if they're reared by people who actually love those children. In First Nations communities, there are many, many people who love the children if their parents are unsuitable. There are lots of aunts and uncles. Many of them are professional people. Some are nurses, lawyers, accountants, some are truck drivers and some work in factories, the same as anyplace else.

In many First Nations communities, there are people who come from abusive environments. The father may have been an alcoholic. Because you've been exposed to an alcoholic parent, you're going to be seen to be a person at risk, even though you may not drink at all. Because of the circumstances you grew up in, it's a mark against you. If you were in a residential school, that's going to be a mark against you. Most people who have suffered those circumstances don't want to rear their children that way; as a matter of fact, they go out of their way to spare them from the experiences they suffered in life.

Those things are not taken into account properly. There needs to be a specific aboriginal home study to qualify for foster care under customary care because of the circumstances our people have experienced throughout life.

The Chair: Thank you very much for your presentation and for your answers.

MARK AUSTERBERRY

The Chair: We'll move to the next presentation now, Mr. Mark Austerberry. You can start any time you're ready. You have 15 minutes total time. If there's any time left, we'll ask some questions of you.

Mr. Mark Austerberry: Good afternoon, committee members. My only previous presentation before a political body was about 15 years ago when I appeared before the mayor and city council of the former city of North York, where a handful of others and I voiced opposition and recommended changes to a proposed residential development. Even though the developer had their own expert address the city council, after I spoke the developer voluntarily agreed to make changes to the development as per our desire. I hope to be equally persuasive to this committee in what I am about to say today.

1700

My ex-wife has a couple of decades of experience working as an insurance broker, having sold a great many personal lines insurance policies. Years ago, when she was then my wife, the vice-president of the Insurance Bureau of Canada appeared on a local radio call-in show and answered a number of callers' questions. Later, after the show was over, my wife stated that some of the information this vice-president gave to callers was incorrect. She stated that to really know what's going on, you have to be someone working in the trenches. So although this person may have been qualified to be vice-

president, to really know the consumer of the service, it really helps to be working in the trenches.

Having myself been a recent consumer of the services offered by a children's aid society, I'd like to think that I'm someone who is in the trenches. I appear before this committee today to voice my opposition to the proposed changes to section 68 of Bill 210, which greatly reduces the accountability of children's aid societies by significantly weakening the complaints procedure against these societies.

After reviewing the Ontario Association of Children's Aid Societies' position paper titled Proposed Child and Family Services Act Amendments, I note that the recommendations on page 45 of this document very closely resemble the proposed changes to section 68 of Bill 210. The Ontario Association of Children's Aid Societies' position paper attempts to justify these changes—to remove complaints to the board of directors and to the ministry director—by saying that the board of directors has not proven to be an effective complaints-resolution step, given the reluctance of board members to overturn decisions made by social work staff and the society's executive director. The ministry director has also proven to be an ineffective complaints-resolution step, given the lack of statutory authority to overturn or rescind decisions made by a society.

Secondly on section 68, complaints against the society are further weakened by proposing that the complaints policy change from a written policy, reviewed and approved by a director, to one that is established by each individual children's aid society. Ontario's chief child and family services advocate, Judy Findlay, confirmed the ineffectiveness of making complaints against an individual with a children's aid society. In a publication titled *Voices From Within: Youth in Care in Ontario Speak Out*, Ms. Findlay writes, "Often, each step up the complaints ladder seems to simply legitimize the decision made by the person previously reviewing the complaint. There is a lack of independence and impartiality in reviewing complaints. Using the advocate to facilitate a more unbiased review is often discouraged by staff."

Last week, this committee heard from the Ontario Ombudsman. In a press release dated December 7, 2005, Ontario Ombudsman André Marin writes, "Currently, my office cannot accept complaints directly about children's aid societies, even though we receive hundreds of complaints each year," and further adds, "It is deeply disturbing that my office is unable to help our most vulnerable citizens: children who are at risk."

Although Bill 210 is not addressing the following item, it is again a further indication that accountability of children's aid societies and their workers is being reduced and eliminated. Child protection workers employed by a CAS are trained in social work and indeed work in social work. Yet children's aid societies in Ontario do not require their workers to hold membership in the Ontario College of Social Workers and Social Service Workers, an organization established by the 1998 social service act to maintain standards and that has the ability to discipline its members.

Another organization, the Ontario Association of Social Workers, in a release titled Ontario Association of Social Workers Admonishes CASs for Reduced Accountability, "strongly recommends that a regulation be established requiring all children's aid societies which hire individuals with academic degrees in social work to require these individuals to register with the Ontario College of Social Workers and Social Service Workers," and makes a compelling case in this report on why this should take place.

In Ontario, no individual can work as a lawyer without being a member of the Law Society of Upper Canada, no individual can work as an engineer without being a member of the Association of Professional Engineers of Ontario and so on, yet persons dealing with our most precious resource, our children, are not required to be a member of any professional body.

Failure of sound system.

The Chair: Someone must have had their BlackBerry close to the microphone. Go ahead.

Mr. Austerberry: In a publicly available document, Marvin Bernstein, director of policy development and legal support of the Ontario Association of Children's Aid Societies, attempts to justify his organization's support for the weakening of the complaints procedures by writing, "External accountability will continue to exist for CASs through ministry audits and other statutory review mechanisms, as well as through ministry approval of CAS multi-year results-based plans and by means of independent agency accreditations."

So what have I described so far? Children's aid societies' unwillingness to have their workers have membership in any professional and accrediting body, such as the Ontario College of Social Workers and Social Service Workers; children's aid societies' unwillingness to have the complaints procedure reviewed and approved by any third party; children's aid societies' admission that they are unwilling to follow ministry recommendations with respect to complaints made against them; and children's aid societies' unwillingness to have complaints against them heard by any third party.

A political analogy of what happens when an organization operates without accountability and oversight would be the so-called federal Liberal Adscam, which is currently being investigated by Justice Gomery.

Most of us are familiar with high-profile cases of individuals who, through no fault of their own, are charged, tried and convicted of crimes when they are completely innocent: Susan Nelles, the nurse who was charged with murdering babies in her care and later completely exonerated; Donald Marshall, convicted of murder and later exonerated and compensated for his time in jail; and many other similar cases. I once read an article on how such travesties of justice occur. That article was by a psychologist who, after examining many such cases, concluded that these travesties of justice occur when individuals charged with investigating the police and prosecutors ignore and dismiss compelling evidence that these persons are innocent because they believe them-

selves to be morally superior, without fault and, by extension, beyond any questioning of their judgment and motives.

This raises some questions. Are children's aids societies unwilling to take complaints against them seriously because they believe themselves to be morally superior? Do children's aids societies rally to the support of one of their own because they believe they are without fault? Is the judgment of a CAS child protection worker with a diploma in social work from a community college beyond question? Does such a person have the wisdom and experience to be beyond question? If not, then why is it the habit of a children's aid society to dismiss, out of hand, complaints against its workers?

1710

I have with me a discussion paper put out by the federal Department of Justice titled *Allegations of Child Abuse in the Context of Parental Separation*. Pages 20 and 21 describe the background and outcome of the case known as D.B. versus CAS of Durham Region. Mr. D.B., whom I have met and heard his story about this case, is rather infamous for being the first person in Canada to successfully sue and win damages against a children's aid society. Despite the Durham region CAS putting up a vigorous and lengthy defence, they lost their case in 1994 and were ordered to pay Mr. D.B. a considerable sum of money as various forms of compensation.

Basically, the case involved two separated parents fighting over custody of their two children. The Durham region CAS case worker unjustly took sides with the mother. The allegations of the Durham region CAS against Mr. D.B. were found to be groundless, and Mr. D.B. ended up winning sole custody of his two children.

The decision went to the Ontario Court of Appeal, which upheld the decision against the Durham region CAS, which was found to have been considerably negligent and acting in bad faith. According to Mr. D.B., the CAS case worker in question has never been disciplined by the CAS and continues to work for them. What did they learn from this? Did they learn not to take sides in a custody dispute?

Going from the Durham region CAS case in 1994, fast-forward a decade to my involvement with a children's aid society. My ex-wife and I were involved in high-conflict litigation involving our two children, where I found, in my opinion, a children's aid society worker again unjustly taking sides in the dispute, which caused considerable emotional and financial damage to my family.

Have I made a complaint to the children's aid society, and if so, did my complaint have any effect? Was it taken seriously? The fact that I'm appearing before this committee asking for changes in the way complaints are handled against children's aid societies should answer those questions, I trust.

One person who has appeared before this committee wrote with regard to complaints against a particular children's aid society, "Through my experience with the complaint procedure the CAS is currently offering, it is

highly unlikely that they are capable of auditing themselves. In fact, it is more likely that once a complaint has been heard, they react as if they have been 'tipped off' and rush to destroy evidence and cover up their misdeeds."

So what would I like to see in place of the proposed changes to section 68 of Bill 210? The answer is two things: first, an effective complaints procedure formulated and approved by an independent third party, and secondly and most important, an independent third party with the ability to review complaints against the children's aid society with decisions binding upon such society.

Ontario Ombudsman André Marin points out that there's currently less independent oversight of child protection issues in Ontario than exists in other provinces. The changes to section 68 of Bill 210 would even further weaken this. Thank you.

The Chair: Thank you very much for your presentation. There is no time left. You were right on 15 minutes. So thank you again.

KAROL KAROLAK

The Chair: We will move on to the last presentation of the evening, as far as I know. Is Karol Karolak here? Mr. Karolak, please have a seat. There will be 15 minutes for your presentation. If there's any time left, we'll allow some questions to you from the members.

Mr. Karol Karolak: Thank you for the opportunity of speaking in front of this committee. My battle with the CAS was long and hard. The battle over the custody of my children is still ongoing. I've been to the court. Last Tuesday—allegations—all my photographic evidence and everything I did was dismissed and used against me. I've been punished once again for trying to protect my own children. It is well documented. My son was abused in front of my eyes—sexually abused, pretty much. I don't want to get into details of this. Probably most of you have read all the materials I've been sending out over the last three years. I have photographic evidence if anybody wants to take a look at it.

The allegations that I made in court the last Tuesday were not even disputed. They were not repudiated. They were dismissed out of hand. I don't even know where to start with what is wrong with the CAS and what is wrong with what we're trying to do as a society. To be honest, we would have to start about 5,000 years ago with the cavemen and cavewomen; however primitive that society was, at least they had children. It seems like we, as a society, are heading for extinction. We've got to a point where no man wants to marry and no woman wants to have children on her own for fear, especially some of them, of those children being stolen after they're born. Given the fact that there is fully available abortion, given the fact that we have fully available contraceptives, women have control over whether or not they want to have children. That's a very difficult task; they have to carry this child for nine months and try to raise them for

another 20. The only thing this woman really needs to commit herself to such a tremendous undertaking is someone she can rely on who will stand by her. So she needs a man in order to decide to have a child, because it takes the two—even more. It's not only his commitment; it's his mother's commitment, his father's commitment, and pretty much the whole family's commitment.

Now we're talking about the man who is going to decide to share this burden with the woman. He would like to be something more than a throwaway subject. Four years ago, I was a very successful consulting engineer, working for a US firm. One of the things I was working on was developing a system on how to apprehend people anonymously sending anthrax through the US postal system. I was developing machines that would produce US postage at the rate of half a million dollars per hour in face value. I was very appreciated for what I did. Four years later, my business has been completely destroyed. My relationship with those people is destroyed beyond repair. I haven't been working for over a year now.

At the time, I was forced to pay more money than I was making. In court on Tuesday, despite the fact that I informed the judge that I haven't been working for a year—child support is supposed to be based on income. I will still pay, I don't know how, or maybe I will pack up and leave like so many fathers that already did. These people are bailing out of this country left, right and centre. Why? Because nobody wants to listen to anything they have to say. All the evidence, all this manoeuvring of the children's aid society, all these fraudulent letters that were sent to my ex-spouse, both copies, and the section 68 review by Mr. Giesbrecht, who has a side business that you all know about—he co-operates with the children's aid society to get money on the adoption deals.

1720

In the good old days, there were children who were somehow orphaned or abandoned by their parents. Today, they are a very precious commodity. We should be very careful about how we tread in these waters, because what happens right now is that we're wiping ourselves out. Yes, we do. It seems like nobody wants to look at it, face it, and say, "OK. We'd better start to rethink this whole deal about this co-operation and financing of private organizations that have a great many purposes other than protecting children." There are a great many ways to spend this money that have nothing to do with child protection. That's the way it is.

As an adult, if I'm stripped of all my rights in front of Family Court, at least I can count on police protection 24 hours a day, seven days a week. My children, on the other hand, are granted protection five days a week from 9 to 5, when most of them are at school and are very unlikely to be abused, but in those hours when it mattered, there was nobody there.

My son put a belt around his own neck in front of my eyes as a result of abuse. There was nowhere I could go with it. I tried the police. They would submit to CAS.

Unfortunately, I would have to return my children on Sunday by 6, and they would arrive at my place on Friday at 4. There was no way I could take my child—no matter how badly he behaved, no matter what happened—to the children's aid society. So I would report to the police and they would report to the children's aid society. The worse that would happen is that on Monday someone would call my ex-spouse, who would turn everything around. This child, standing next to the person who abused this child so badly, wouldn't tell anybody at the CAS what actually occurred.

So where do we stand today, three and a half years later, after the gathering of all these documents? I was very patient. I went through the whole process. I went through the whole complaint process with the children's aid society of the region of Peel. Duly noted, all the manoeuvres they did: They were shredding of the documents they didn't like. They lied. Then I go through the section 68 review. The lawyer who does it lies, but he's better at it. He lies by omission. He omits the facts that were on the record but would not—

The Chair: If I could give you a suggestion, the word "lie" is not a word we allow. So if you can use another word, it would be appreciated.

Mr. Karolak: So "misrepresentation": He misrepresents by omitting facts.

Then I go to the Ombudsman's office, and at the Ombudsman's office, certain facts were selected. Out of the whole list of misgivings of the children's aid society, only certain facts were selected for the review. As it turned out, yes, the lawyer missed certain facts. He missed mentioning my son's underwear. He missed mentioning all the documents and the pictures that ended up in court. He missed so many other things that were indicative of the prior abuse of all three of my children. Nevertheless, even the Ombudsman wouldn't—I'm so radical in my opinions. You have all heard about these baby breeding farms and baby stealing and baby selling and this artificial—what is that?

Ms. Kathleen O. Wynne (Don Valley West): Insemination.

Mr. Karolak: —artificial insemination to resolve the birth crisis in Canada. None of that is true, but I wrote it and I sent it to all of you just to show you the possibilities that are out there. This is all in the realm of possibilities. If somebody has a crooked enough mind, he can use the system to do exactly what I wrote about in my letters. To this very day, nobody is willing to investigate whether or not my allegations are true. I sent them to the police, I sent them to the RCMP, I sent them to the provincial government and the federal government. The only letter I received, recently, in response to my allegations is from the International Criminal Court.

I don't know. We should at least try to preserve decorum. Even if we don't try to preserve decorum for the citizens of this province, we should try to preserve decorum in front of the rest of the world, because people read this stuff, and there are enough coincidences and things that somehow—this conflict-of-interest thing.

People are connected in such a way that, from outside, from where I sit, it all looks possible, it all looks plausible. So if somebody in Europe gets a letter with all those documents where it seems plausible to me, it looks almost certain to them. We shouldn't really shame ourselves in front of the world in the way we do things.

There are so many other things I would like to say if I were to be permitted another chance to speak in front of this committee, because we would really have to look into what child abuse results in. There is very good research being done by Dr. Martin Teicher, at the Psychiatric Hospital in Boston, where he tells that this is what causes all the mental problems people have later in life. This abuse has an almost irreversible effect. There is

a very good article, Scars That Won't Heal, and anybody can look it up on the Internet. This guy is an expert. People write right, left and centre about it. We should look into that and start from there. How are we going to go about it and be serious? Not some piece of legislation that's going to be twisted left, right and centre.

The Chair: Mr. Karolak, thank you very much for your comments. There is no time for questions, but we thank you for what you presented to us.

At this point, there are no other presentations, so the meeting will be adjourned until tomorrow at approximately 3:30, when the final presentations will take place. Thank you and good evening.

The committee adjourned at 1729.

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Tuesday 13 December 2005

Journal des débats (Hansard)

Mardi 13 décembre 2005

Standing committee on social policy

Child and Family Services
Statute Law
Amendment Act, 2005

Comité permanent de la politique sociale

Loi de 2005 modifiant des lois
en ce qui concerne les services
à l'enfance et à la famille

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 13 December 2005

Mardi 13 décembre 2005

*The committee met at 1605 in room 151.*CHILD AND FAMILY SERVICES
STATUTE LAW AMENDMENT ACT, 2005LOI DE 2005 MODIFIANT DES LOIS
EN CE QUI CONCERNE LES SERVICES
À L'ENFANCE ET À LA FAMILLE

Consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts / Projet de loi 210, Loi modifiant la Loi sur les services à l'enfance et à la famille et apportant des modifications complémentaires à d'autres lois.

The Chair (Mr. Mario G. Racco): Good afternoon. Welcome to the meeting of the standing committee on social policy in consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts. The agenda for today is full. Unfortunately we are half an hour behind, so keep that in mind when you ask questions and make comments.

It is the fourth day of the four-day schedule, so this will be the last day. I want to remind the membership that before we leave today, we may wish to discuss the clause-by-clause timing. Keep that in mind for the end of the meeting, please.

CHIEFS OF ONTARIO

The Chair: With your permission, I will start with the first presentations: Chiefs of Ontario and the Association of Iroquois and Allied Indians. You have 15 minutes for your presentation. If there is any time left, we will be able to ask some questions. Please start any time you are ready.

Regional Chief Angus Toulouse: First of all, I'd like to acknowledge the Mississaugas of New Credit, whose territory we're at today.

The Chiefs of Ontario is a secretariat which acts on behalf of the 134 First Nations based on resolutions passed from time to time at general and special chiefs assemblies. I'd like to acknowledge this opportunity to make a presentation to the committee on the all-important topic of child welfare in general, and Bill 210 in particular.

Child welfare is a high priority for First Nations. I'd like to acknowledge Minister Chambers and also the parliamentary assistant, Linda Jeffrey, for taking the time to meet with our chiefs' committee on child welfare on at least two occasions. I was really glad to sit down with Minister Chambers yesterday to talk about her wanting to know much more about First Nations people, and certainly wanting to educate herself on our history and of the good work that our chiefs' committee is doing and various First Nation activities in this whole area. It was really good to see the minister taking the time to sit down and work with us in that regard.

In Ontario, our First Nation families were affected by the infamous child scooping and adoption practices of child and family services agencies which continued well into the 1960s. Individuals, families and communities are still suffering the consequences today. This negative experience was one of the factors behind the significant infusion of First Nation provisions in the current version of the CFSA. The key First Nation part of the act is part X. While the provisions are not perfect, they are generally viewed by First Nations as a significant form of protection against past abuses, and a recognition of the special circumstances of First Nations. First Nations want to build on these provisions, not diminish them.

Among other things, the CFSA established respect for Indian culture as a fundamental principle within the preamble. The CFSA required that decisions about a First Nation child by the courts and child welfare agencies be based in part on consideration of the culture and traditions of that child and his or her community. For example, the CFSA made provisions for First Nations to represent as full parties, in protection cases, their collective interests in those children and families who become involved in the system.

First Nations take the position that their inherent right to self-government, which is confirmed by section 35 of the Canadian Constitution Act, 1982, includes jurisdiction over child welfare. This means that First Nations can pass independent laws dealing with child welfare. This jurisdiction is being implemented gradually. In the meantime, it is recognized that CFSA has a direct impact on First Nations families and children. Therefore, First Nations have a direct interest in any changes to the CFSA, particularly any changes to the existing First Nations provisions in the CFSA. My purpose today is to outline procedural and substantive concerns that First

Nations have with Bill 210, which proposes to amend the CFSA in different ways.

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Inadequate consultation: Based on section 35 of the Constitution Act, 1982, the government of Ontario is obliged to consult First Nations in a reasonable way when draft legislation is likely to prejudice First Nations' rights and/or interests. This obligation has been confirmed in several leading decisions of the Supreme Court of Canada; for example, the decision in *Delgamuukw v. BC*. It is clear that some of the CFSA amendments contained in Bill 210, which are outlined below, do prejudice First Nation rights and/or interests. Therefore, the constitutional duty to consult is triggered.

There's also a legal duty to consult First Nations based on section 2.2 of the 1965 welfare agreement, which is an active federal-provincial cost sharing agreement dealing with various social programs, including child welfare.

In summary, the province is under a legal duty, constitutional and contractual in nature, to consult First Nations on those parts of Bill 210 that affect First Nation rights and interests. The required consultation must be fair and reasonable. It cannot be pro forma or in bad faith. The honour of the provincial crown, in its dealings with First Nations, is at stake. Failure to consult according to the legal standard can lead to the invalidation of parts or the whole of the legislation.

The duty to consult has not been satisfied in the case of Bill 210. There has been little or no effort to consult First Nations. The consultation problem is illustrated by the current committee process which originally took no account of First Nations' input. First Nations had to protest to get a minimum level of involvement. Therefore, if the bill is passed into law in the immediate future, there is a real risk that parts, or even the whole, may be struck down in court later on. First Nations are ready to work with the government to identify reasonable changes to the legislative package.

Customary care is a fundamental component of the First Nations' approach to child welfare. It is also a fundamental component of part X of the CFSA. Only First Nations themselves can define and implement First Nations' customary care. The opening and all-important section 208 of part X of the CFSA provides as follows:

"208. In this part,

"'customary care' means the care and supervision of an Indian or native child by a person who is not the child's parent, according to the custom of the child's band or native community."

These all-important words recognize First Nation customary care and First Nation control of such care.

A major concern with Bill 210 is the new regulation-making power that would permit the provincial government, with little or no notice, to define and redefine First Nation customary care, in particular section 44, which amends section 223 of the CFSA, an existing regulation-making power that only applies to part X of the CFSA. Section 223 of the CFSA currently permits regulations exempting First Nations and other First Nation-related

entities from parts of the CFSA and regulations, requiring consultations with First Nations in certain cases. These existing regulation authorities represent the positive approach of part X and the CFSA.

In contrast, section 44 of the bill adds a paragraph to section 223 of the CFSA, permitting regulations "governing procedures, practices and standards of customary care." This undermines part X in a fundamental way. It undermines the principle that customary care is in the control of First Nations. Customary care will be subject to control and change by the province.

The new regulation-making power is consistent with First Nation jurisdiction over child welfare matters. It is necessary for this regulation-making power to be removed from the bill. This definition of customary care should be controlled by First Nations. The province should respect the principles of part X of the CFSA.

Seeing that I'm really running out of time, I'm just going to go to the summary. I know you have the written text and there are other presenters behind me who will talk specifically to some of the experiences that they have. If there's an opportunity to answer a question or two, I'll have the opportunity.

That there are at least two components of Bill 210 that will do real harm to First Nation families affected by the CFSA. First, there is the new regulation-making power that would allow the province to arbitrarily define and redefine First Nation customary care. Second, there is the cut-off of access to crown wards which will affect First Nation children and families in a disproportionate manner, cutting them off from collective cultural supports.

In addition, Bill 210 fails to address fundamental problems with the CFSA in terms of First Nations. There is no guarantee of resourcing for the important role of band representative. There is no recognition of the First Nation prevention philosophy in child welfare as opposed to overreliance on protection in the courts.

Based on what it addresses and does not address, Bill 210 represents a significant pullback from the spirit of part X of the CFSA. This, in turn, represents a significant risk of a gradual return to the bad old days before the modern CFSA. That would not be in the best interests of First Nation children or the province as a whole.

Bill 210 has a significant prejudicial effect on First Nation rights and interests in relation to child welfare. As a result, based on constitutional principles in section 2.2 of the 1965 child welfare agreement, the province is legally obliged to consult First Nations, accommodate their positions and, in some cases, obtain their consent. In fact, the province has not made a serious effort to consult First Nations on Bill 210. This puts the legislation in constitutional jeopardy.

The best course is simple and straightforward. The rush on Bill 210 should be stopped. Instead, the package should be suspended to permit meaningful consultation with First Nations. If the consultations are conducted in good faith, the inevitable result will be a better legislative and program package. This will be in the best interests of the children.

That's a quick presentation in going right to the summary, understanding the time limits that we have today.

The Chair: Thank you. There is 30 seconds for each party for questions.

Mrs. Julia Munro (York North): I'm trying to digest this. I did have a question and I'm afraid I can't do it in 30 seconds, so I'll pass. Thank you very much for bringing such a thoughtful presentation forward.

Mr. Howard Hampton (Kenora-Rainy River): You've delineated many problems with the amendments that have been proposed by the government. Is it fair to say that what you would like the government to do is to stop this process insofar as it might affect First Nations or has the potential to affect First Nations and begin a longer-term consultation process with First Nations to arrive at some measures which have the support of aboriginal people and which will work for aboriginal people? Is that a fair conclusion?

Regional Chief Toulouse: Absolutely. Actually you hit it right on, Howard Hampton. Our long-term goal is our own First Nation child welfare act, which means that we drive it with our own jurisdictions that would protect our children, as historically we've always had. Long before the colonization of our people, we managed our own affairs with our own families and our own children. So we're more than capable of continuing to do that.

Mr. Dave Levac (Brant): Thank you, Chief. It's good to see you. Do I have this correct, that your understanding is that rights are according to the constitutional agreements that the province signed off on, which could make this process that you're concerned about in terms of the consultations remove the bill from validity? That means you see that if we do move into the consultation phase you're recommending, that would be more protective of the constitutional agreements you've referenced and protect the bill in its desire to improve the circumstances for the kids.

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Regional Chief Toulouse: Absolutely. I think any measure of consultation that is developed by us and agreed to by your government certainly would go much further than something being imposed, that has no consultation from our viewpoint and from our people. I think we're more than willing to engage in developing a consultation process that's more meaningful and makes more sense.

The Chair: I will certainly let Minister Chambers know your comments. Thanks for your presentation.

ANISHINABEK NATION UNION OF ONTARIO INDIANS

The Chair: The next presentation is from the Anishinabek Nation; Mr. John Beaucage, please. You can start any time you're ready, the usual 15 minutes total.

Grand Council Chief John Beaucage: First of all, I'd just like to correct something that was missed in the

House today. I was in the House for most of the afternoon and there were no birthday greetings for Mr. Leal. I understand there was another birthday today that was recognized, and we all forgot Mr. Leal. So happy birthday, Mr. Leal.

Mr. Jeff Leal (Peterborough): I appreciate that.

Mr. Hampton: How many?

Mr. Leal: Well, it's not 39.

Grand Council Chief Beaucage: I bring you greetings on behalf of the 43 member First Nations of the Union of Ontario Indians. Our territory stretches from Thunder Bay to the Ottawa Valley in the east and from the north shore of Lake Huron and Manitoulin Island to Sarnia in the south. The Union of Ontario Indians represents over one third of the First Nations people in Ontario.

It's a pleasure to make this presentation to the standing committee on social policy. I would like to thank all those members who met with me earlier today on another matter, involving Bill 36, the health integration act. I look forward to making that presentation to you in the near future.

Today I wish to raise some of our concerns and recommendations concerning Bill 210, An Act to amend the Child and Family Services Act. I have organized my presentation into four main areas: authority and jurisdiction, consultation requirements of the government, customary care and termination of access.

With regard to authority and jurisdiction of First Nations, it is important for the government of Ontario, within its legislation, policy and initiatives, to recognize the special status and rights of First Nations, which are based on section 35 of the Constitution. There are two sets of rights that are protected. These include aboriginal rights and treaty rights. Aboriginal rights are all those rights that are inherent and not addressed by treaty. Responsibility for the safety and security of the next generation was bestowed upon First Nations by the Creator. It is an inalienable and inherent right that has not been and could never be extinguished by any agreement, treaty or otherwise.

The legislation process undertaken to amend the Child and Family Services Act fails to recognize the authority and jurisdiction of First Nations in child welfare matters. It is important that any law passed, especially with regard to the future of our children, include the jurisdiction and involvement of our people.

We recommend the following measures: An amendment is needed to this legislation to recognize First Nation jurisdiction and rights. This amendment would state that First Nations authority and jurisdiction be recognized by Ontario in all matters pertaining to child welfare, including involvement in the legislative process as well as program development and delivery. In addition, provincial standards must be replaced by First Nation standards regarding foster homes, customary care and safe homes, and financial resources must be allocated to ensure that these are comparable to mainstream practices.

Consultation: With regard to consultation, it is apparent that the government of Ontario has failed to live up to its obligations under the Constitution and under the Supreme Court decisions of both Haida Nation and Taku River, and most recently in the Mikisew decision. The Supreme Court is clear that in any circumstance that a decision, initiative or legislation may directly affect the aboriginal and treaty rights of First Nations, a jointly established consultation process is required. In some cases, when that aboriginal or treaty right is adversely affected, the government has an expressed requirement to accommodate First Nation interests. My question to the committee is this: Has the government analyzed these court decisions and reflected its requirements in this piece of legislation?

I want to be on record with you, as members and as a committee, that the Union of Ontario Indians has not been happy with the government of Ontario's so-called new approach to aboriginal affairs. When this relationship was first put forward, it was pitched as a partnership between First Nations and the government. However, over the past few months, new policy and legislation have continued to be developed unilaterally. This is certainly not indicative of a true partnership and certainly doesn't respect the government-to-government relationship that the Union of Ontario Indians is insisting upon.

Further, Ontario has stated in their aboriginal policy framework and the new approach to aboriginal affairs that they are dedicated to developing processes for consultation with First Nations. However, this has not happened with regard to Bill 210. I want to make it clear that First Nations have not been consulted on this bill and the proposed amendments to the Child and Family Services Act.

I recommend the following: that a commission be developed specifically to address First Nation issues, and ask that that commission hold public hearings on Bill 210; secondly, that a jointly developed consultation process be developed, based on principles expressed in our written submission; and that consultation should be carried out as early as possible so that it is meaningful to the implementation of the initiative and provides the best protection for all parties' rights.

Customary care: Section 10 of the Child and Family Services Act was established as a means to provide for customary care. It is the contention of the Union of Ontario Indians that Bill 210 and its amendments do not adequately reflect the spirit and intent of section 10 of the legislation. Customary care remains an open-ended concept for the purpose of allowing First Nation communities the flexibility to determine their own customs regarding alternative care for children in need.

The province, under Bill 210, is removing the authority of First Nations in determining their customs for caring for children and placing responsibility for these arrangements with the government. This is entirely unacceptable to the Union of Ontario Indians, our 43 member First Nations and, frankly, all the First Nations in Ontario. As far as I'm concerned, this is an affront to our people.

My recommendation is straightforward: Strike section 44 of Bill 210 to preserve the authority of First Nations currently protected under the Child and Family Services Act regarding customary care. Furthermore, the subsidies provided to alternative care homes, including customary care homes, on First Nations must be equal to the rate non-natives receive for their foster homes.

Termination of access: In an attempt to address the impediments to adoption for crown wards, section 17 of Bill 210 calls for termination of all access orders for any child made a crown ward. We certainly have a concern in this regard due to the close and sometimes complex extended family relationships we have with our children in our communities. There have been many cases on our First Nations that a child has been made a ward of the crown and has maintained strong relationships within their community and their extended family. The proposed changes, however, will terminate all access, with children's aid societies as the only partner permitted to apply for openness orders. Once again, this does not consider the needs and special circumstances of our First Nation children nor does it respect the wishes and jurisdictions of that particular member First Nation. By terminating all access orders, vital relationships between the child and extended family members will be severed. The repercussions of such actions to the development and well-being of First Nations children have been demonstrated by similar attempts to sever vital relationships through the residential school experiences and the sixties scoop.

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Just to elaborate a little bit on the sixties scoop, because of the residential school experience, there were generations of our people that lost their parenting ability. Parenting was not a skill that was passed on because the children were taken away from our communities and sent to these residential schools. In the 1960s, some of these problems manifested themselves in a care problem with our children. Children's aid at that time came into our communities, took these children away and adopted them outside of our communities. They were adopted in huge numbers to urban areas and lost all their contact with our people and with their families. As a result, you had a whole number of people growing up without the benefits of the teachings of their families at home. That's the sixties scoop, and we don't want that to happen again.

In addition, these proposed changes fail to take into consideration the backlog in family court that could impede the process of obtaining an openness order, which would result in disruption of contact between children and their families. It is our recommendation that section 17 of the act be rephrased to allow for a seamless transition of access orders into openness orders where the relationship is still in the best interests of the child. Access orders should not be terminated unless they meet the current requirement under the Child and Family Services Act, that the access order is not in the best interests of the child or impairs the child's opportunity for a permanent or stable placement. Secondly, the act should give equal right and opportunity for all parties to apply for an openness order. This will ensure that families and

significant people have an avenue to pursue to re-establish contact with a child once they are made crown wards.

Additionally, the legislation should include provisions to enforce adherence to the native provisions of the CFSA to ensure the rights of First Nations children and their communities are protected.

In conclusion, I respectfully ask the standing committee on social policy to ensure that Bill 210, An Act to amend the Child and Family Services Act, first and foremost, respect the constitutionally protected rights of First Nations people in Ontario. These include our aboriginal rights, our inherent rights and our treaty rights. For so long, the government has developed legislation, initiatives and policies in isolation from First Nations people and our governments. As in the past, the government continues to do what it sees as in the best interests of our people, and in this particular case the best interests of our children.

Ladies and gentlemen, I want to state something so simple that it may even sound absurd: From our perspective, it is First Nations parents, communities and governments that know what's best for our own children.

We expect the government of Ontario and this Legislature to uphold the Constitution and our rights protected therein. We also expect the government of Ontario to live up to its rhetoric to include First Nations as an active partner in the development of policy and legislation. Ensure that the recommendations of the Union of Ontario Indians contained in our written submission and this presentation are incorporated into the final reading of Bill 210.

Meegwetich. Thank you very much for your attention.

The Chair: Thank you for your presentation.

SIX NATIONS OF THE GRAND RIVER

The Chair: The next presentation is from the Six Nations of the Grand River, Chief David General.

Chief David General: Before I begin, Mr. Chair, I would ask your indulgence to allow two other people to sit with me, please. They've been my sidekicks in the House committees in Ottawa and also in the Senate.

The Chair: It's a pleasure to have both of the ladies with you. You can start any time you wish. If you need more seats, we will be happy to add them.

Chief General: I'll try to get through it as quickly as possible.

My name is David General, Chief of the Six Nations. Before I begin my presentation, I'd just like to say that we've been on this treadmill of the FMM. Probably one of the most important discussions that came out of the FMM was not about money, but about the recognition of the place of our women in our communities. It was advanced to the assembly that if we look after our women, if we honour and care for our women, we will have strong, healthy children and strong, healthy communities, and that delivers strong, healthy nations. I use that as a backdrop to what I'm about to present. Again, thank you very much for the opportunity.

On behalf of the people of the Six Nations of the Grand River, I would like to offer greetings to the standing committee on social policy. I am David General, elected chief of the 53rd Council of Six Nations. In attendance with me from the Six Nations community is Arliss Skye, director of social services, Councillor Melba Thomas, who's a portfolio holder for that, and Elder Josephine Harris.

First, I would like to take the opportunity to acknowledge the cooperation that has been extended to us this day. Initially, these committee meetings were scheduled for last week. Unfortunately, that posed a scheduling conflict for us. The Assembly of First Nations Special Chiefs Assembly was scheduled for last week. We sought an alternative time and our request was granted. Thank you for exercising your discretion. You've exercised a degree of flexibility in your busy schedule in order to accommodate our busy schedule. I trust the presentation today will be worth the wait.

Part X of the Child and Family Services Act is a unique component of the laws of Ontario. Subtitled "Indian and Native Child Family Services," this part provides provincial recognition of the unique position of aboriginal peoples in Ontario.

Further, part X is unique in its progressive outlook in the consideration of aboriginal people.

It is the product of considerable thought and deliberation. It provides a platform for further development. With the great diversity of First Nations within the boundaries of Ontario, further development should always be expected. However, for these further developments to be of mutual benefit, full and meaningful consultation must take place.

The great diversity of First Nations within the boundaries of Ontario is no small point to be taken for granted. In order to illustrate the point, consider the following: If you were to cut out a map of Ontario and then superimpose that map over Europe, how many different European nations would then be covered? How diverse would be the group of people? In that manner, one should similarly consider the great diversity of First Nations within the boundaries of Ontario. The Cree of the north are distinct from the Ojibway, and the people of the Six Nations are distinct from the nations mentioned above.

Today, I would like to deliver the following message: Six Nations has the ability to take care of its own. We have the talent, we have the ability, we have the desire and we have the commitment. All we need is your further co-operation. Your co-operation is required in the following way: We need the opportunity for our capable bureaucrats and technicians to review the proposed changes. In brief, we need the opportunity to consider the full implications of part X of Bill 210, the Child and Family Services Act, or more specifically, how the proposed changes of Bill 210 will affect the delivery of services to aboriginal communities.

In order to have the full and complete consultation on Bill 210, Six Nations and all First Nations need the opportunity to complete our own internal consultation.

We require further time to discuss these considerable changes with our own people. We need to talk to our directors, our policy advisors and our lawyers. This all requires more time. Therefore, our discussion today must not be considered as consultation. Today's discussion will focus on the need for an extension of time to enable us to do our work. After the work is complete, only then can we have full and complete consultation.

In the spring of 2005, the current government presented its new approach to aboriginal affairs. With its insightful subtitle, "Prosperous and healthy aboriginal communities create a better future for aboriginal children and youth," I, along with other leaders in First Nations communities, were hopeful that it would indeed mark the start of a new approach.

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To refresh our memories, I would like to remind you of the opening paragraph from Ontario's New Approach to Aboriginal Affairs: "Ontario is charting a new course for a constructive, co-operative relationship with the aboriginal peoples of Ontario, a relationship that is sustained by mutual respect and that leads to improved opportunities and a better future for aboriginal children and youth." I agree and concur with Grand Council Chief John Beaucage when he says, "To this point in time, we're a little disappointed."

I believe that everyone in this room is working for the better future of aboriginal children and youth, as everyone in this room, as a parent, is working for a better future for each of our own children. Bill 210 touches on fundamental aspects of the new approach. Most importantly, Bill 210 addresses those children who are not our own children but those children who are most in need: those children who need protection. For everyone in the room, I have no doubt that there is a general desire to help all such children, regardless of background or location. I hope we can use our mutual interest and find a mutually agreeable solution.

On a preliminary basis, the majority of the proposed amendments may be beneficial. The proposals would be flexible and adaptable to the cultural environment of the agencies. However, Bill 210 also proposes some amendments that may have adverse consequences on part X of the Child and Family Services Act; more specifically, to the amendments that may affect the delivery of services to aboriginal communities.

With the announcement by the Liberal government of the new beginnings, we may be on the threshold of a new era. To cross this threshold, we need to rethink our roles and apply our knowledge and skills to the tasks of disassembling the past, which must be left behind, and assembling what we want and need to have for our future. We need to blend the past, the present and the future to serve our nations.

We ask the standing committee to have the courage to respect the view of First Nations. We ask the standing committee to encourage the government of Ontario to work together with us in a practical, concrete way to advance the vision of taking care of our own.

The people of the Six Nations believe that we have the solutions for child welfare on Six Nations. The solution: allowing our people to apply our traditional practices to our community. In the past, outside practices have not worked. The solution will be found in our traditions and in our people.

I'd like to thank you very, very much for the opportunity to present here today. Again, I go back to the teachings I have received from my community and my elders. Our children are a gift. They are something the Creator provided to us, with the responsibility that we be there at every step of their development. We—their parents, their grandparents—are responsible for them. We applaud any effort of any government to make sure that children are safe, but in the development of any new legislation, we need to be included. It's a very, very important part, and I bring that message from the elders at Six Nations.

Season's best to all.

The Chair: Thank you, Chief. General. There is about a minute each for questions. Mr. Hampton, would you like to start?

Mr. Hampton: If I can jump ahead, I suspect that some government members are going to take the position that some mistakes were made in drafting of this bill, but those mistakes can now be fixed by introducing a few other amendments. What I think I hear you saying, however, is that trying to put in a few amendments at a later time is not going to fix a process that has been fundamentally flawed from the beginning. What I think I hear you saying is the government should stop. If it wants to proceed with those elements of the bill which would not affect First Nations, would not affect aboriginal children, and if it's prepared to give an undertaking that they would not be applied to First Nations and would not be applied to aboriginal children, you might be prepared to live with that. But insofar as this could potentially affect aboriginal people, aboriginal children and First Nations, I think what I hear you saying is you want the government to stop and begin a real process. Is that a fair assessment?

Chief General: That's a fair assessment, Mr. Hampton. Also, we're talking about the duty to consult being between the government and First Nations. Myself and council as a government on our First Nations, we also have the duty to consult our people. Something as important as the issues of child care, welfare and safety—that has to grow from the community up. Too many times, the care and attention that should be provided is directed down, and I think there needs to be this consultation building from the ground up so there's buy-in from the communities, from the nations. That's going to be the strength of any changes or amendments to your legislation.

The Chair: Ms. Jeffrey.

Mrs. Linda Jeffrey (Brampton Centre): Do I have a minute?

The Chair: Less than a minute.

Mrs. Jeffrey: That's not enough time to ask any questions. We're grateful that you accommodated our schedule as well to be here today, and we thank you for

your thoughtful presentation. You're right, you do have the talent in your own community to take care of your children, and I look forward to seeing the amendments that we'll bring forward to reflect what you've asked for.

Chief General: *[Remarks in native language.]*

The Chair: Ms. Munro, please.

Mrs. Munro: I do have questions, but we don't have time to discuss them. I think it's very important that the parliamentary assistant has given you some assurance in terms of amendments. We'll certainly be looking forward to those, and assume that they are going to be ones that you will have an opportunity to look at.

Chief General: Mr. Chair, we invite any questions that the members of the committee have. Forward them to us. We'll deal with them at the political level, at the administration level. We look forward to that dialogue.

The Chair: Thanks very much. You heard the PA comment and I think that should give you some relief.

NOG-DA-WIN-DA-MIN FAMILY AND COMMUNITY SERVICES

The Chair: We will be getting the next presentation from Nog-da-win-da-min Family and Community Services.

Sir, you can start whenever you're ready. There's 15 minutes total time.

Mr. Bill Gillespie: Good morning; bonjour. I'd like to start with a history of native child welfare in our area.

For over a decade, the First Nations in the catchment area of Nog-da-win-da-min Family and Community Services have been waiting for any significant developments pertaining to native child welfare to take place. Several significant events have taken place over the past 10 to 15 years, but did not involve First Nations. We have not had an opportunity to present our concerns during the amendments to the legislation in 2000 and remain optimistic with the opportunity to present here today to the standing committee.

A ministerial review of the aboriginal agencies was conducted, but that report was never released to the public. Although the final draft number 9 version has surfaced in First Nation communities, the ministry has never officially released this review; any noteworthy facts and/or recommendations to benefit aboriginal communities have never been revealed.

With the latest proposed changes to the legislation, First Nations were not consulted until the process was well underway. With the lack of both human and financial resources, our communities have not been afforded the opportunity to thoroughly review and analyze the impacts that will affect our communities once again.

At present, there are 10 native child and family services agencies in the province that have the task to deliver services to First Nations with the mandate of improving children's lives. Five of these agencies have the child protection mandate and five are pre-mandated and primarily do prevention services. Pre-mandated agencies have very little authority regarding the apprehension and placement of native children, yet we are

expected to keep our children in their communities, or at least as close as possible to their home community and in native homes.

Although Nog-da-win-da-min Family and Community Services has the authority to license our own foster homes, it is up to the children's aid society whether they will utilize our homes. We have a number of children in care, yet we are not able to place every child within our communities. Nog-da-win-da-min continues to advocate for additional resources to expand our service delivery model as we strive to keep our children in our communities.

Severe social problems—for example, poverty, violence, addictions and multi-generational issues—lead to other more traumatic issues for our families. We acknowledge the change in direction from a protection to a strengths-based family and community approach in caring for our children with adequate resources to accompany this. Responding to any reform will be very difficult, given the enormity and weight of the issues, as well as the long-term effects of these issues.

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All children in Ontario should benefit from the reforms and policy changes, especially access to services. Some of the reforms and policy changes are seen as positive and very helpful to our children. We strive to have our children know who they are, where they come from and what it takes to maintain the connections to family, clans and communities.

There is a lack of native agencies to provide culturally based services to native people in the province. We acknowledge that our First Nations leaders have rejected Bill 210 in its entirety until such time as there has been proper consultation. Providing resources to prevent children from going into care is a good investment, as is the flexibility to respond to families when they are in financial crisis, which would result in children going into care with our help.

Families shouldn't be penalized financially for trying to help their own. Prevention and other community services need to be adequately resourced to take on the increased demand for services through differential response. Our belief that native services should be delivered by native people for native people is reinforced by a report by Frank Maidman in October 1998, titled *Aboriginal Child Welfare Prevention Practices Project*.

We view fostering our children as being positive, whether it be through adoption or legal custody. We believe that foster parents should be provided with the training and supports needed to assist in caring for our children. This will encourage First Nation families who would like to assist relatives but do not have the resources to meet the needs of some high-risk/high-needs children and youth, providing the foster parents applying for custody do not bypass the community and the band's party status in these proceedings.

It's not a given that all foster families will maintain access to communities for reasons of culture and identity. This is why access orders enforcing compliance is important. Further, any training or curriculum developed for

foster parents needs to be adapted for First Nations agencies and workers; for example, the Pride Curriculum and Looking After Children.

In order for these reforms and policy changes to be successful, there needs to be a corresponding investment in capacity and infrastructure-building at the community level. This is greatly needed, as many First Nation communities do not have the services available as compared to mainstream agencies. First Nations do not have access to children's mental health services or child development services on reserve, for example. Our children are put on long waiting lists.

Customary care: The ministry acknowledging the use of customary care is hopeful. Our apprehension, however, is in section 44 of Bill 210, which would allow the Lieutenant Governor to regulate customary care. We're basically opposed to the province making regulations "governing the procedures, practices and standard for customary care."

Regulating and/or defining the procedures, practices and standards for customary care falls under the authority of the First Nations. Customary care is a traditional aboriginal custom, and it should be the First Nations communities who develop and define how customary care is practised. Furthermore, customary care is defined and practised differently throughout the province, as developed according to the tradition custom of each First Nation to meet community needs. Customary care practices also vary across cultural groups.

The Child and Family Services Act, as it reads today without any changes, contains provisions that enable the use of customary care by First Nations authority, as facilitated through existing legislative arrangement. These provisions have been in effect and productively utilized for over 25 years. We are firmly opposed to amending the act to regulate customary care, but we are open to work with the ministry to resolve any issues or concerns that have come up.

We are experiencing an increase in apprehensions in our catchment area. Our fear is that if the children's aid society receives an enhanced protection mandate status, they will be even less co-operative with those communities that are now served by them. This will undoubtedly further increase the number of our children being apprehended.

The children's aid society continues to place our children in non-native homes and refuses to place our children in our licensed foster homes that are available.

Inadequate funding and not being able to hire more workers will greatly deter us from resolving problems and maintaining our focus of early intervention. There has been little or no increase in funding since the late 1980s. Actually, there was a decrease of 5% in 1996. Our prevention programs were driven by demand for services beyond primary prevention to include secondary and tertiary prevention. Our recent strategic planning has refocused our programming to do just primary and secondary prevention. Our staff is more than capable of providing prevention services, but they do not have the capacity to meet the existing demand for services.

That concludes my presentation.

The Chair: Thank you. We have about a minute for each party for questions. Mrs. Jeffrey, do you wish to start?

Mrs. Jeffrey: Thank you very much for being here. I have no questions. I appreciate your thoughtful paper. That's very helpful for us to have a sense of what you think is important. I appreciate your being here today, and I appreciate your patience. Sorry we're running late.

The Chair: Mrs. Munro?

Mrs. Munro: Thank you very much for being here with us. Much has been said about the issue around customary care. On page 4, you talk about it as well, because obviously this is a critical part of the concerns you have. In here, it suggests that it should be the First Nation communities that develop and define how customary care is practised. I wondered if you had developed some initial sort of best practices and things like that that you would want to offer as, if I might say, remedies—just simply best practices that you would want to promote.

Mr. Gillespie: I think those are being captured. We have a committee that sits right now. I'm part of that committee, as a member of the association, along with the chiefs' council. We are developing those guidelines, to be reviewed eventually, I guess, by the legislation, hopefully in the future.

The Chair: Mr. Hampton?

Mr. Hampton: I just want to be sure I've got the understanding of this. Your agency is not a mandated agency, so you don't have the child protection/child welfare mandate under the CFSA.

Mr. Gillespie: No.

Mr. Hampton: So you, by necessity, have to work in co-operation with a non-native child and family service agency.

Mr. Gillespie: Yes.

Mr. Hampton: And part of your fear is that where this act is headed, it will give considerably more power to that non-native child and family services agency.

Mr. Gillespie: Yes.

Mr. Hampton: They would not have to take into account culture and extended family. They would not have to take into account the wishes of First Nation leadership.

Mr. Gillespie: Hopefully, they would take into account First Nation leadership. In apprehending our children, hopefully, they would contact our band representative first or go on reserve to investigate any concerns. That is our fear, yes.

The Chair: Thank you for your presentations and your answers.

1700

KINA GBEZHGOMI CHILD AND FAMILY SERVICES

The Chair: The next presentation is from Kina Gbezhgomi Child and Family Services.

Ms. Margaret Maniwabi: Good evening. My name is Margaret Maniwabi, and I come from a First Nation

called Wikwemikong Unceded Indian Reserve. I'm also a board member of Kina Gbezhgomi, which is also a child and family service that is not mandated. We've been trying to seek mandation for a number of years. We became incorporated in 1981.

I'll begin my presentation. You have an outline of what I'm going to present today. It was produced by our executive director. She could not be here, as we are meeting with our foster families and some of the children this evening and having a Christmas party.

The history of Kina Gbezhgomi Child and Family Services: The development and design of Kina Gbezhgomi, which means "We are one," came as a result of the amendments to the Child and Family Services Act in 1985, which provided First Nation communities with certain native provisions in addition to part X of the act, which supports band authority in native child welfare proceedings. Kina Gbezhgomi has been incorporated since 1991 with the original intent, as with all the chiefs of this area, of becoming a protection agency for the seven First Nations; namely, Wikwemikong, Aundeck Omni Kaning, Sheshegwaning, Sheguiandah, M'Chigeeng, Whitefish River and Zhiibaahaasing. We're from Manitoulin Island. I drove six hours to get here, alone, to speak to you today. Fourteen years later, our agency continues to operate as a prevention-based agency, although a number of proposals have been forwarded to the ministry to build our capacity to provide protection services to our community members.

Since 1985, the spirit and intent of the native provisions, including part X, has not been implemented in a manner that truly respects First Nation contribution to the practice of child welfare. Kina Gbezhgomi continues to operate with the same budget that was negotiated with the Ministry of Community and Social Services in 1991. Our budget continues to be \$1.4 million. Comparatively, the children's aid society of Sudbury and Manitoulin districts operates with a budget of approximately \$25 million. Before the child welfare amendments created in 2000, the children's aid society had a budget of \$2.4 million. As you are aware, the funding formula implemented for mandated agencies increased as the number of children in care increased. These children are from our communities.

Manitoulin Island is a beautiful island with seven First Nations. Eighty per cent of the Manitoulin Island work of the children's aid society is with our children.

Our communities were not consulted regarding the reforms in 2000, nor do we seem to be included in the reforms for 2005. Currently, 80% of the children in care of the children's aid society are from our seven First Nation communities. The current risk assessment tool is discriminatory of First Nation realities. The tool does not consider the economic realities of our communities. As you all know, most of the native communities, if not all, in Ontario do not have an economic base. The strengths of the families are not considered, nor the strength of the extended families or the community.

Currently, families who are referred to the children's aid society and are eligible for child welfare service

receive a standardized intake investigation as prescribed by the Ontario risk assessment model. The implementation of this model has crippled our ability to respond effectively to the ever-increasing number of apprehensions occurring within our jurisdiction. Over the past five years, the amendments to the Child and Family Services Act have devastated our families and communities as we have lost yet another generation of our families to the child welfare system.

The intergenerational effects of residential schools and the well-documented sixties scoop compound the mistrust and trauma suffered by our communities. The residential school impacts are still very much alive today as we are faced with families raising children by those very survivors who were tortured, sexually abused and forced to forget their culture, languages and customs that bonded native families and communities. The sixties scoop was also an era that reached through the 1970s and into the 1980s, whereby a disproportionate number of native children were forcibly removed by well-intentioned social workers who believed that our children had to be removed from our communities in order to protect them.

Today, a number of these survivors are involved in the child welfare system with their own children being removed from their care. The lack of infrastructure within our communities to address the intergenerational effects of our past is compounded with the lack of both human and financial resources to address the multiple issues faced by our communities. However, the resiliency of our families and communities continues to be demonstrated and documented, and we believe that our communities possess the strengths, knowledge and skills necessary in keeping our families and communities together.

Band representation as defined in Child and Family Services Act: The CFSA provides for band representation as legal parties since 1985 in the various decision-making processes regarding native children and is intended to ensure that our children are cared for within our own respective communities. The CFSA further permits the minister to exempt a First Nation agency from sections of the CFSA, which broadens the scope of developing a truly unique and culturally appropriate approach to child and family services. The power and authority to effectively represent our community's interest in protection cases has been compromised, as the native provisions lack regulations from the ministry to ensure that mainstream societies adhere to the consultation process with First Nation communities and the placement of native children with extended families within our communities.

Regardless of the native provisions and part X, the amendments to the Child and Family Services Act, 2000, have further resulted in a significant increase of our children being apprehended, leading to the adoption of our children to non-native foster homes throughout the province.

Our communities' interest in protection cases has been compromised by long debates between the federal and provincial governments and lack of commitment to

ensuring that First Nations remain as an active party to all child welfare proceedings involving our band membership. The lack of funding to support the role of the band representatives further impairs our ability to respond to numerous protection cases filed by the society. Some communities can no longer afford to participate in child protection hearings, as we do not possess the additional funding required to support this critical role within our communities.

In 2003, First Nations were advised that Indian and Northern Affairs no longer has the authority to fund our band representation program, stating that the treasury board has taken the position that the band rep program is an anomalous activity.

Currently, my First Nation, Wikwemikong, which has a population of approximately 8,000 on and off reserve, is using its Casino Rama dollars to fund this program. We would like to use our Casino Rama dollars on economic development, but currently we are using them to hire three of the band reps in our community, and they go to court all over Ontario. As a matter of fact, one of the gentlemen who was supposed to be here this evening left the community on December 7, to go down south toward London and Windsor. He is supposed to be back here this evening. Those are the kinds of things we're struggling with, not only my reserve but other First Nations.

Further to this, the provincial government fails to recognize and support the native provisions contained in the Child and Family Services Act by providing regulations and funding for First Nation communities to respond as a community to children involved in the child welfare system.

Customary care provisions: Under part X, "customary care" means "the care and supervisions of an Indian or native child by a person who is not the child's parent, according to the custom of the child's band or native community." Further, "Where a band or native community declares that an Indian or native child is being cared for under customary care, a society may grant a subsidy to the person caring for the child." Currently, we don't get a subsidy. If you go into customary care, we have to run to the welfare office to ask for some money to look after that child.

I looked after a child and received \$210 a month, which is \$7 a day, to take care of a young lad—all his needs.

1710

Currently, customary care is a voluntary arrangement, not regulated under the Child and Family Services Act, which may be entered into by the child, the child's parents or the child's band, pursuant to the band's customary care declaration and arrangements with the children's aid society. A customary care agreement may be changed or extended as long as all parties who participated in the original agreement consent to any changes or extensions. Customary care arrangements must remain within the authority of the child's community, and that cannot be governed by the time restrictions for children in care.

First Nations communities have advocated for the placement of children with customary care givers for over 20 years—and long before that—with very little consideration provided by the mainstream children's aid society. The reality is that raising children in today's economy often forces well-intentioned family members to relinquish the care of their children simply based on the fact that they cannot afford to care for another child. As a result, our children continue to be placed in ministry-regulated foster placements as defined in the Child and Family Services Act.

When a child is apprehended by the children's aid society, that caregiver gets \$25 a day, but for us, it's \$7 a day if we look after that child.

Customary care is distinctly different from foster care, as the standards and regulations for licensing requirements do not consider First Nation customs, practices and realities. Customary care must remain as a First Nation-driven and controlled process in order to effectively deliver the decisions and processes that are required by the service providers, families and leadership.

Given the expansion of family-based care opportunities for children in the current welfare transformation, the need to regulate compliance rates of mainstream society to engage First Nations is essential. There has never been any regulation or policy or practice in place to assess the compliance rate of non-native children's aid societies, including: notification requirements; consultation with First Nations, including the apprehension of children, the placement of children in residential care, the placement of homemakers and the provision of other family support services; the preparation of plans of care; status reviews under part III; temporary care and special needs agreements under part II; adoption placement; the establishment of emergency homes; and the practice of customary care as defined in the legislation supported by a subsidy for our customary care givers.

The Chair: Thank you for your presentation. We've run out of time, so there's no time for questioning. We have the statement, of course. We all have this to make reference to. That was all of your presentation, am I right?

Ms. Maniwabi: That's right, but the rest is in here.

ONEIDA NATION OF THE THAMES

The Chair: The next one is the Oneida Nation of the Thames. You can start any time, sir.

Chief Randall Phillips: Thank you, Mr. Chair. I didn't prepare a written submission for you. It's not my style to provide written submissions. The other thing too, as I'm looking at this, is that you've got a mountain of paperwork and for the most part I think they're reflective of everybody's concerns. That's another reason why I think I saved myself and the committee the heartache of reading through another one. Nevertheless, I hope the committee does take my points and what I have to say into consideration when dealing with this particular topic.

I bring you greetings from the Oneida Nation of the Thames. My name is Randall Phillips. I'm the current

elected chief at Oneida. I'm a member of the bear clan. I say that simply because it's important when we have these discussions about customary care that within Oneida, we have a different family line. I want to say that now, and I'll get back to that point a little bit later.

First of all, what I want to do is talk a little bit about Oneida. I'm representing a community here that is one of three Oneida communities throughout North America. That forms our nation—our nation. I just want to repeat that. We're not a First Nations community; it's a nation. It's that kind of thinking that I want committee members to start to realize. I certainly understand that what we're here to talk about is legislative amendments, but where I'm coming from is a different reality with respect to that. I just want committee members to appreciate that.

I say that I'm elected to council, because we have two styles of governments back home. One, we have a traditional council. The traditional council for Oneida Nation is made up of nine titleholders. Out of those nine titleholders, eight of them reside within our community, and it is that very fact that presents some challenges with respect to governance issues. Certainly it has an impact when we talk about customary care and the responsibility and the right to protect children and, again, for a notion within customary care.

Within those nine titles, we're part of a larger confederacy called the Iroquois Confederacy, which has 50 titles. Those are all family lines. It's important to know when we start talking about extended family clans that within that confederacy there are also responsibilities to help other nations.

I want to start the presentation with something the last speaker talked about, a little bit of background as to why we're here in the first place, and that is the first amendments that happened in 2000. I think they set the background and the context for what we're dealing with here today, and I don't think they were done in a good way.

One of the first things that was mentioned was that we weren't involved in any consultative process with regard to any of those amendments. One of the fundamental changes that occurred at the 2000 review was the change in terms of the paramountcy of the act. What they had done was to take a provision that allowed for native children to be placed primarily within their culture and change that to considering the child at risk. It was a fundamental change. What it did was put the child into a different context, and that's what we're dealing with here today.

The other thing that is important to recognize is that the children are always going to be part of that culture. I believe you've heard presentations made here that, simply because our children get adopted out, that doesn't mean they don't come back to our communities in terms of seeking their family lines. They do come back. They will always come back. So there is no dissociation here; there's just a period of disruption in terms of their lives.

The other thing that happened in 2000 was that they changed this notion of thresholds, which unfortunately for impoverished communities like mine had a dramatic

effect, because once you've lowered the thresholds to see whether or not these places are safe or can accommodate children, they're lost. We don't reach that threshold. Unfortunately, that occurred in too many of the households there. An idea that each child had to have a separate bedroom—I don't know the familiarity of the committee members, but within a native community we're subjected to standards with regard to housing. They're all built on the same sort of building block. This notion that you're only supposed to have one or two children and that's it, and if you go over three, then of course your house doesn't accommodate that any more, creates difficulties. The other thing that was mentioned was the introduction of new clinical assessments in schools that I think are very culturally inappropriate. All of these changes that I mentioned are just the highlights, but they lead to the context in terms of where we are today.

I'm going to be very short on this next part because you've heard it. I've heard it nine times today and Mrs. Jeffrey, I'm sure, has heard it a thousand times because she's been involved with us in terms of other meetings. It's this notion of consultation. Quite simply, it is a legal requirement. Quite simply, we're looking at it from a different process than maybe other people would with respect to consultation. You've come to me and said, "What's your opinion?" and we've consulted. That's certainly not our view and not our definition of "consultation." Again, we take a look at that in a different context.

There is a reason why there are legal requirements when you're dealing with First Nations. Once again, I don't know the history or the experience of these committee members, but it's certainly something it would behoove you to look into.

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I certainly support, and Oneida supports, the idea of a separate process to deal with these issues. In 1985, when we did the native provisions, there was a glowing example in terms of why we need a separate process to deal with First Nations communities specifically. I think this again deals with that. So with the notion of consultation, I would be looking specifically at some kind of specific process to deal with the Oneida nation.

One of the things I want to talk about quickly here is, what are the impacts on this community? We've talked about legislation. What's the impact in terms of the community? I want to go over a list of a few things in terms of what the changes I've outlined have done, and what these potential changes you're talking about will do.

First of all, there has been increased involvement by the CAS in our community as a result of the legislative changes. Our people haven't become any different; our situation hasn't changed one iota. Something else changed to spark this increase. It creates an increase of hardship in terms of our financials from a band administrative point of view to deal with these issues, to deal with this increase. You heard the lady before you say that her band rep worker isn't here because he has to be someplace else. It's a direct result of that increase in

terms of the CAS involvement that we've got people all over the country—not necessarily within our own little ridings, but all over the country and certainly all over the province.

We haven't received any real increase in terms of resources from the ministry to provide this kind of function over the last many years. There may have been small notional gains, but certainly not enough to address the concerns we had outlined.

It creates an increased strain on the family and community supports. The more people we have involved in the system now requires more and more involvement from other agencies, other services to ensure we provide the right kind of protection and the right kind of environment for those children. It certainly has increased the caseload for our workers. Certainly, on reserve it has. One of the things we haven't talked about or I haven't heard today is the notion of the citizens who don't live on a reserve or on our territory. Within Oneida we call it a settlement. There are some significant cases that were mentioned here: the Musquis case, which talks about employment access, and Corbiere, which talks about election. Those things were granted by the federal government to extend to all First Nations people. So by definition we can't limit ourselves to only concern ourselves with what goes on within our communities. We have to look at all our children, regardless of where they reside.

At Oneida we've expended an awful lot of resources in terms of cultural and linguistic programs—millions of dollars over the last couple of years. What's going to be the impact here, and why we are doing this, is for the children. Now we have a system we're fighting that is directly opposed to that by trying to remove our children from that. Once they're gone, they don't come back until after they're 18 or 19 years old, and of course you realize that at that point in time the acquisition of a new language becomes much more difficult. There's a time frame when you're supposed to learn your language and your culture, and that is when you are young. Removing them from that environment doesn't help that at all.

There is a recognition that we can take care of our own that needs to be accepted. We've been working at this and we tease about it. Unfortunately, we tease about it that, as chiefs, we administer our own poverty. We're given such scant resources to try to cover a variety of social issues, economic issues, that it makes it very difficult and the challenges to balance those types of budgets are very difficult. But we've survived and we continue to do so. What we're looking for is support.

One of the areas I want to talk about with respect to the bill is this notion of accountability. Currently, the way I read it, there are no accountability mechanisms for the CAS regarding any program initiatives. Who do they respond to? Who do they answer to, the board of directors? I was on a board of directors for our local CAS. Certainly they don't answer there; that's for sure.

We talk about a change in the complaint process or a recommendation to limit or put the complaint process

right back on CAS officials, and that's something I don't agree with. Who do we complain to then? I mean no offence by this, but new, young overzealous employees who kind of fill the gap of a new CAS because they've got an increase in load—why aren't they questioning why they've got an increase in load rather than just bringing in more human resources to deal with that? I find that surprising: why the committee hasn't tried to address that or why nobody has tried to address that. I think it's reflective of my accountability issue that CASs don't have to deal with that.

As First Nations communities we've dealt primarily with the Department of Indian and Northern Affairs—judge, jury and executioner all in one. I see that very same thing, the same vein, the same theme happening here with the CAS. They're judge, jury and executioner.

There's no accountability in regard to the existing native provisions in there, and I think that would be helpful. Let's have a report card in terms of how CASs do this. It is separate. There's a separate part X with specific native provisions. Let's have them accountable for that.

Regarding notifications, sometimes we get them, sometimes we don't. Sometimes we get them a day before the court hearing and can't get up there. Somebody needs to be called on that.

Information-sharing: When we ask for this—the legislation calls for the band rep to be privy to this stuff—we get hurdles and roadblocks put up. I think the notion of representation has been addressed with regard to the band rep and the problems and struggles they have there.

With respect to crown wards, I also don't agree with this notion of termination of access simply by becoming a crown ward. Again, going back to 2000, they changed the time limit to one year. So if there were any problems, then certainly within that one year they may not be addressed and this will unilaterally terminate that.

It's the same concern with adoptions. This whole idea of permanency, I think is a rush. I think Bill 210 just kind of fills the gaps in terms of what Bill 6 didn't do, and so there's a problem with that.

Mr. Chair, I appreciate the fact that I'm running out of time. I'm going to be real fast here.

Similarly with regard to customary care, going back to our nation, we have family lines. They have responsibilities. That needs to be recognized and we need to be supportive so that can happen. That's our customary care. It's not going to be a best practices model that happens on Manitoulin Island. It's not going to be a best practices model that happens in Kenora. It's going to be a best practices model that is culturally relevant to the Oneida Nation of the Thames.

Finances: We've talked about finances here. Who's going to pay for these things? How are we going to do this? I think this is important, and I'll end on this statement right here. With respect to this, there's a 91% return from the federal government to take care of this particular issue. So what we're talking about now is an added burden on the province of Ontario. Rather, what

we should be doing is that the province of Ontario should be supporting First Nations and directing those monies directly to us.

The legislation allows for the recognition of agencies, societies and First Nations authorities. Let's talk about that. Let's leave that there. Certainly that provides us with an avenue for resources.

In closing, I want to say two things: First of all, I certainly appreciate the time you've taken to listen to my rants and raves, but I also want to say that 15 minutes is not adequate to discuss these kinds of issues. Fifteen minutes is not adequate for anybody to outline these types of things. I've heard committee members today acknowledge the fact that they've got questions on their minds, but can't ask them because of the time restraints. If questions don't get asked, then they won't get answered. So there's a gap there.

I just want to tell you that not everything seems to be as bad as it is. Certainly as First Nations we want to be involved directly in the new relationship with government processes that deal with our family and our people.

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At Oneida, we have a program that's called Project HUGS. Every month, we try to contact all the crown wards and bring them back to our community; every month, we try to do that. We just had a little Christmas party and, unfortunately, I met three new ones.

I'm a representative of the Chiefs of Ontario committee on child welfare. I'm the president of Mnaasged child and family services, which is pre-mandated. I'm chief of my community. I've been on the board of directors of a CAS. I think what we need to do is to start to change that—start to change our involvement so that it does not have a negative impact on our children for years to come.

The Chair: Thank you, Chief, from the Oneida Nation. You went over by four minutes, but that's understandable; we have no problem with that. We have made exceptions for other people too, but we try to stay within the 15 minutes. Your comments have been heard by all. I'm sure we will keep that in mind for next time.

ASSOCIATION OF NATIVE CHILD AND FAMILY SERVICES AGENCIES OF ONTARIO

The Chair: The next presentation is from the Association of Native Child and Family Services Agencies of Ontario. You can start any time. There's a maximum of 15 minutes, please, as there are other people waiting.

Mr. Ernest Beck: Thank you, Mr. Chair, and members of the standing committee. By way of introduction, my name is Ernest Beck. I'm the current president of the Association of Native Child and Family Services Agencies of Ontario. I'm accompanied today by Ms. Betty Kennedy, who is the current executive director. Given the time restraints, I'll try to go right to the guts of this submission, which will be available to the committee

upon completion. Hopefully, at the end of these proceedings, we'll have a positive outcome.

Firstly, in terms of process, we acknowledge that our First Nations leaders have rejected Bill 210 in its entirety until such time that there has been proper consultation. We stand behind and support the position of our leadership. The disproportionate number of aboriginal children in the care of the child welfare system is a widely known fact. This situation warrants serious consideration, and immediate short- and long-term planning and consultation with First Nations needs to occur. First Nations have never relinquished the right to care for our own children. The agencies stand in solidarity with their First Nations in this resolve.

As stated in a report released by the association in 2001, "The responsibility for the safety and security of the next generations was bestowed upon First Nations by the Creator—it is an inalienable and inherent right that has not, and could never be, extinguished by any agreement, treaty or otherwise. Thus, when speaking of native child welfare issues in Ontario, it is important to understand that regardless of the federal and provincial legislative environments, First Nations are first and foremost governed by tribal authority."

The focus of our submission to the standing committee on social policy corresponds to the purpose of our organization, and thereby centers on practice and service delivery implications of Bill 210 as an interim measure toward reclaiming full aboriginal authority on child welfare. The primary objective of the Association of Native Child and Family Services Agencies of Ontario is to ensure that any changes to the child welfare system result in improved service delivery for the aboriginal children, families and communities we serve. Our feedback is intended as technical in nature, and should not be construed as consultation with First Nations.

Our membership is diverse, consisting of mandated aboriginal children's aid societies and pre-mandated aboriginal child and family service agencies. Our agencies range in the services they offer from on-reserve, off-reserve, and urban to remote and across different aboriginal cultural groups. It may also be said that our agencies serve along a cultural continuum, making mainstream services available within the context of more traditional cultural services. We may adapt a service to meet the needs of the children, families and communities we serve. Nonetheless, all of our agencies will face various changes in their child welfare programs and practices with the passage and implementation of Bill 210.

Overall, feedback from our membership has been indicating that the majority of changes expected with the proposed amendments would be welcome, in that they would be flexible and adaptable to the cultural environment of the agencies and may help produce or enable improved service delivery and outcomes. However, the bill also proposes changes that may have negative consequences for our children, families and agencies. The following are some comments, concerns and recommendations of the association in regard to Bill 210.

To begin, we would like to acknowledge the change in direction from a protection to a strengths-based family and community approach in caring for our children as a move in the right direction. This positive new approach will require adequate resources in northern and remote areas of the province and especially in First Nations communities.

As the reader is undoubtedly aware, many aboriginal communities are struggling with poverty, violence, addictions and multi-generational issues. The enormity and weight of these issues on our children and our communities make it very difficult to respond to any reform, let alone the long-term effects of the issues. The responsibility rests in large part with only 10 native child and family services agencies. Presently, only five of these agencies are mandated to provide child protection services. In this regard, we believe the major capacity-building initiatives proposed by the Minister of Children and Youth Services' child welfare transformation agenda should be focused on First Nations. The ministry's current funding arrangement is flawed and does not reflect adequately the realities faced by our communities. It should instead be redesigned to provide equitable access to service to meet the needs of our mandated and pre-mandated agencies.

While we perceive alternative dispute resolution, differential response and some elements of permanency planning as a step in the right direction, concerns are also raised as to the insufficient resources and number of First Nations agencies mandated to implement these approaches. This is especially critical as it relates to the lack of designated First Nations agencies in southern, central and northeastern Ontario. This situation could produce the unintended consequence of further placements of aboriginal children in environments that are not First Nation-based, culturally appropriate and/or that do little to strengthen the partnership with First Nation communities.

We also have concerns with the proposed amendments in Bill 210 relating to status reviews and custody orders. These amendments, if passed, would have the effect of foster parents' rights superseding the rights of parents, extended family and community. There is no acknowledgement that the First Nation must approve of custody orders. Any custody orders of a First Nation child must be sanctioned by the First Nation.

Reform efforts to increase accountability can only be viewed as positive. However, despite First Nation-specific provisions in the Child and Family Services Act, there are still inadequate checks and balances in the system concerning aboriginal children. Although the native agencies have been regularly subject to reviews, the non-native agencies have yet to be reviewed in regard to their adherence to the aboriginal provisions of the act. Our pre-mandated agencies continue to work with non-native CASs that may or may not be adhering to these provisions. Overall, our pre-mandated agencies experience a lack of meaningful consultation and involvement in all levels of service planning.

We are encouraged to see the ministry acknowledging the use of customary care. Of primary concern for the association, however, is the provision in section 44 of Bill 210, section 223 of the act, which would allow the Lieutenant Governor to regulate customary care. We are fundamentally opposed to the province making regulations "governing procedures, practices and standards for customary care." Regulating and/or defining the procedures, practices and standards for customary care falls under the authority of the First Nations. Customary care is a traditional aboriginal custom. It is not a practice in the realm of expertise of mainstream governments and decision-makers.

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Furthermore, customary care is defined and practised differently throughout the province, as developed according to the traditional custom of each First Nation to meet community needs. Customary care practices also vary across cultural groups. Should the provincial government take on this task, which is ultimately outside their area of authority and expertise, there is a high likelihood that the resulting regulations, even if well-meaning, could place undue restrictions on the use of customary care and have extremely negative effects on First Nations' ability to continue to practise customary care effectively within our communities.

The Child and Family Services Act, as it reads today, without any changes, contains provisions that enable the use of customary care by First Nation authority, as facilitated through existing legislative arrangements. These provisions have been in effect and productively utilized for over two and a half decades. While the association would agree that changes to the child welfare system are required to better support and strengthen the use of customary care, it is not necessary to change the act, as proposed by Bill 210, to do so.

The association understands that the ministry and a number of mainstream child welfare agencies may be unclear on the actual procedures, practices and standards for customary care. We also understand that the provincial government may be concerned about liability issues. We agree these types of concerns and questions are important to address and resolve, and we are prepared to work in partnership with the provincial ministry to do so.

We are, however, categorically opposing the amending of the act to regulate customary care. There are alternatives for clarifying the practice and addressing concerns outside of amending the act, as is currently proposed. In fact, the association is currently conducting a project jointly with the Ontario child welfare secretariat to resolve these outstanding concerns.

We do have some recommendations with regard to some of the concerns raised in this presentation.

Recommendation 1: The association recommends strongly that the Ministry of Children and Youth Services pursue an appropriate and thorough consultation process with aboriginal leadership in respect to Bill 210.

We make the following recommendation as well, regarding reviews facilitated through the Child and Family Services Act.

Recommendation 2: In order to ensure that the rights of First Nation children, families and communities are upheld, the Association of Native Child and Family Services Agencies of Ontario recommends that all child welfare review processes utilized by the provincial government include aboriginal representation on the review committee, as sanctioned by the First Nation.

Specific to the contents of the bill itself, the association puts forth these additional recommendations regarding section 4. We note that there's no obligation in the new subsection for communication with the child's First Nation, and make the following recommendation.

Recommendation 3: The association recommends an additional subsection be added to section 59 of the act to recognize that if a crown ward is an Indian or native child, contact must be maintained between the child and his or her First Nation.

Regarding section 27, we note that there does not appear to be any provision for extended care and maintenance to apply to customary care arrangements, and make the following recommendation.

Recommendation 4: The association recommends that an additional subsection be added as follows:

"(3) Where a band or native community has declared that an Indian or native child is being cared for under customary care, the society may continue to provide care and maintenance in accordance with the regulations."

Regarding section 24, the association makes the following recommendation.

Recommendation 5: The association recommends that this proposed amendment be removed from Bill 210 so as not to have the effect of foster parents' rights superseding the rights of parents, extended family or the First Nation community.

Regarding section 44, the association again makes the following recommendation.

Recommendation 6: The association recommends that this proposed amendment be removed from Bill 210. Further, we recommend that the Ministry of Children and Youth Services work with the Association of Native Child and Family Services Agencies of Ontario and First Nation leaderships—for example, the Chiefs of Ontario office—to resolve any outstanding concerns related to the practice of customary care.

In summary and conclusion, our legal and constitutional rights were ignored in this whole reform process and, as such, we recommend a full judicial review.

Second, we are adamantly opposed to any amendments that restrict, exclude or impinge in any way on the operations of part X. Accordingly, all amendments should be redrafted to ensure that there is absolutely no negative application to the native provisions.

Third and finally, furthermore, there are significant costs associated with effective implementation of any amendments or other aspects of transformation, let alone part X. We strongly recommend that any and all funds being provided to mainstream agencies be evenly matched and directed to First Nation agencies to facilitate the necessary growth and development of part X.

The Chair: Thank you, Mr. Beck and Ms. Kennedy. The 15 minutes have been used up. Thanks very much for your presentation.

CHIPPEWAS OF NAWASH

The Chair: The next presentation is from the Chippewas of Nawash. There are 15 minutes for your presentation. You can start any time.

Mr. Anthony Chegahno: I would like to thank the chairperson, as well as the members, for this opportunity to share briefly—I don't want to rehash a lot of information that you've had, so I'll try to restrict my comments to about 10 minutes. Somebody else—maybe Mr. Hampton—can use my five minutes.

I would like to thank Andrea Horwath, as well as Mrs. Chambers. As I was reading the government remarks, they mentioned that it was important to get comments from the stakeholders, and that meant a lot to me as I read these comments. It is very important that you talk to stakeholders in anything that deals with legislation that's going to be passed.

I work with native child welfare on Cape Croker. It has different names. The English name is Cape Croker. The Anishnawbe name is Neyaashiinigmiiing, and I guess the government name is Chippewas of Nawash. I've worked with this, and I want to come from the perspective of a social worker, I guess.

I'm very concerned about this bill and how it presents to many First Nations. The Chippewas of Nawash First Nation has a special responsibility and interest to provide for care of the children of members of the community of the Chippewas of Nawash in a manner that is First Nation specific, First Nation determined and community-based. That's important to us—to any community.

As you look overall at how Toronto is broken up, it's broken up into areas where certain ethnic groups live. I look at this and I want to see fairness when you're dealing with First Nation people. As First Nation people, we have a special status, which is recognized in treaties as well as provisions in the Indian Act, the Constitution of 1982 and the Ontario Child and Family Services Act of 1984.

The key thing I want you to remember is that First Nation children are the natural resource of the future of our nation, not only the Anishnawbe nation but Canada as a whole. Our livelihood depends on this concept. Our children are very, very important to us. The best interests of First Nation children should be recognized and protected. That's the Chippewas of Nawash intent.

I was reading also that the standard refrain we commonly hear all over Ontario about child protection is, "It's in the best interests of the child." As First Nation people across Canada, we strongly believe this. We hold this dear to our hearts. Every First Nation child should be encouraged and assisted to develop to his or her fullest potential. That's what drives us: that we can leave a legacy for our children. The family, including the extended family, is the first resource for care, affection, nurturing and protection of our children.

1750

Preservation of native cultural identity is important in terms of language and customs for all First Nation children, and Bill 210 does not say how to meet the needs of our language and customs that are very important for our First Nation children.

The decision-making process regarding the provision of service and delivery of any service specifically to First Nation children must involve First Nation people, with proper consultation. I guess you've heard that all day: proper consultation.

Our First Nation is responsible for the planning, design and delivery of prevention programs appropriate to First Nation custom, culture and way of life. We ensure that a range of family and child protection services are delivered to First Nation residents.

We provide a range of approved placement resources for children within the community pertaining to customary care. Many of the speakers before me have said that each First Nation, because of the uniqueness of the First Nation, has a different interpretation of what customary care is.

My friend from Manitoulin Island said that because customary care is not recognized, many times a band has to foot the bill to provide customary care. I don't think that's fair. There should be a level playing field. That's what the Constitution of Canada pertains to. It says there is fairness for everybody. But when a community has to foot the bill to keep its own children within the community while the act provides that CAS can provide better money for home care, it's not fair.

The placement of native children in a foster home on the First Nation shall be a responsibility as a team. It's not only the responsibility of the First Nation. Through customary care, which this bill fails to recognize, I believe we can come to an understanding. You can't omit something that is very dear to our hearts and customs. You can't do it with the stroke of a pen. I urge you to reconsider and make some proper amendments that would meet First Nation needs right across the board.

What else can I say? As a former worker at a CAS, when you see your family being apprehended, that's one of the hardest things you can see; seeing them leave your community and saying, "When am I coming back?" We need our children within our community.

Along with other First Nations in Ontario, we are fundamentally opposed to certain provisions in Bill 210 that undermine First Nation children's practices in our jurisdictions. In particular—and many have quoted it—section 44 of the bill gives the government open-ended regulatory power to redefine First Nation customary care.

This bill affects First Nation rights and interests. The government of Ontario is under a legal obligation to consult First Nations and attempt to accommodate those rights and our interests. We strongly believe in the importance of our children.

The provincial government has not lived up to its legal duty to work with First Nations on key provisions of Bill 210. The consultation record of this bill is practically

non-existent. As a result, we oppose the bill as it is written and ask for consultation for First Nations input before you attempt to bring it to another vote.

We have quality staff who can take care of our children. Many of them have gone through the courses that are required by the children's aid society.

One of the chiefs said, "A child is a gift from our Creator." I strongly believe in that, and how we train that child so that when he or she is old, they will not depart from those teachings that are very, very dear to our hearts.

You can't fix a flaw, like a cracked windshield in your car. You can't fix it; it will always be a flaw. As the winter comes and you turn the heat on, that crack starts to grow more. Pretty soon you're making amendments here, you're making amendments there. Throw that windshield away and put a new one in. What many First Nations are asking the government to do is come for full consultations. That's what we need. Honourable member Hampton has asked that question. It's very important to us that you come.

If you want to come to the communities, you're more than welcome, just to see how the process has worked. If you want to come and see many of the homes that we have in the communities that are below the poverty line, come and see. Many times when the elections are coming around, that's the only time we see some of our elected officials. Come and see us each and every day, or when you're in a community, drop in and see where your dollars are being spent and how wisely we are spending them on the limited income that is brought forward.

If you don't have questions, feel free to come to my community. We'll welcome you with open arms. We'll show you what we have, but most of all we'll show you our children, who are our future. They're your future. They could be the future members of Parliament. One of the greatest things that we have is those teachings that we give to them through customary care, through whatever aspects are adapted by our culture. I can't help but reiterate that a child is a gift. Each and every one of the mothers say that is important; when your children are growing up and they begin to leave the nest, how that hurts. That hurts even more when our children get apprehended and taken out of our community. That's their community; that's their home; that's my home. That's part of the home that I'm willing to share with you if you want to come and see how the Chippewas of Nawash operate. Meegwetich.

The Chair: Thank you for the invitation and for your comments. We have a minute each. I'll start with Mrs. Jeffrey.

Mrs. Jeffrey: Thank you for your thoughtful presentation and thank you for the invitation. We appreciate your patience today; I'm sorry we're running late. Thank you for being here today.

Mrs. Munro: I appreciate the comments you've made today. Members of the committee, obviously, have heard many of the issues that have been raised, but I think that your way of presenting them has allowed us to remember

exactly why we're all here, and recognize that it is all of us, as parents and grandparents—that's really what the whole initiative is about. The parliamentary assistant has made comments about looking at amendments, and certainly that's what we will be looking at as we go forward.

Mr. Hampton: My fear is I think the government believes that by a few strokes of the pen over here and a few strokes of the pen over there, they can fix what is wrong with this bill. What I think I heard you say is that while amendments might be appreciated, there is something much deeper and of much greater concern here that cannot be fixed by amendments. The government has to sit down with First Nations and work in partnership with First Nations to fully understand how important these issues are to aboriginal people, to aboriginal children and to aboriginal governments. Fair assessment?

Mr. Chegahno: That's a fair assessment.

The Chair: Thanks very much for your presentation.

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NISHNAWBE-ASKI NATION

The Chair: The next presentation is from the Nishnawbe-Aski Nation, and it's Stan Beardy, Chief. You can start any time, sir.

Grand Chief Stan Beardy: *Remarks in Oji-Cree.*

I won't speak too much, Mr. Chair and members of the committee. I'm from Muskrat—300 people. It's about 1,000 miles from here and I spent \$3,000 to be here for 15 minutes. I don't want to speak too much in terms of the legislation itself, about the suggested changes, but I want to try to share with you our history with the Confederation and also with the province of Ontario.

The point I'll put across here is that until such time as we are allowed to run our own lives, until such time as our inherent right is recognized that we are capable of looking after ourselves, nothing will change. I want to start off a little bit with the residential school experience.

I want to mention too that I'm from Muskrat and we're not on a power grid. We depend on generator sets to operate our lights and our computers. Last night, the power was out, so I was not able to produce a written handout at this time. However, I'd like permission to send a summarized written presentation, perhaps tomorrow. By the same token, I was not able to reproduce any copies and I only have one copy of everything which I managed to gather as well.

I should mention as well that I am Grand Chief of the Nishnawbe-Aski Nation. Our territory covers two thirds of Ontario. Our borders are from Manitoba, Hudson Bay, James Bay, Quebec and roughly the 50th parallel, and roughly two thirds of the landmass of Ontario—210,000 square miles. As I mentioned earlier, we have 50 First Nations in there and roughly 45,000 people. Roughly 70% of the total population is under the age of 29; unemployment within that group is roughly 85%.

Suicide among my young people—as young as nine years old—is roughly eight to 10 times the national average. At the present time, we have three child care agencies within Nishnawbe-Aski: Tikinagan, Payuko-

tayno and Kunuwanimano—it's a Cree word. The reason I mention those statistics is the fact that outside legislation has been imposed on us many times without any consultation, without any accommodation. I mentioned the result of the statistics I just outlined as a direct result of that outside legislation being imposed on us without any meaningful input or consultation or dialogue with the people. So we produced a document that outlines the legacy of residential schools. When you grow up in an institution, for example—which 90% of my people were exposed to or impacted by—you lose parenting skills, you cannot pass your teachings down because the culture, the languages are lost. The statistics I outlined are the result of that outside legislation being imposed on us.

The other thing I want to share with you is what we call the sixties scoop. That was only 40 years ago. The province of Ontario had this policy where they went around Indian reservations, kidnapped our children and shipped them all over Ontario, all over Canada and the United States, Europe—the world. That's called the sixties scoop. In some cases, the province of Ontario 40 years ago issued death certificates for children so that we cannot trace them. I have documentation here of some of those cases.

I'm trying to point out to the committee members that we are real people. We have families too that we care about. I talk about the suicides that are 10 times the national average. I'm talking about somebody's children here. I'm talking about somebody's grandchild. I'm talking about somebody's sibling. We too have feelings when we lose our children. This is the work of the Ontario government 40 years ago and that's why I appear, that's why I travelled from so far away, to try to convince you that we are people too. We have families, we have dreams like everybody else. We live in Ontario and there has to be consideration given to us as people.

I have here as well an article that appeared in the Citizen and the Globe and Mail, I think it is. We just located one of our people from Cat Lake who was locked away in a mental hospital for 46 years because this person went out as a child, five years old, and he was not diagnosed properly. He was blind, but because he couldn't speak English he was locked away in a mental hospital and we just found him 46 years later. This is the effect that those outside legislations impose on us. That's why it's so important that you work with us to make sure things like this don't happen. We're talking about the year 2005. We just found this person 46 years later, who has been locked away somewhere.

Here as well I have a brief outline of some of the devastating impacts of residential schools and what it does to individual people, a race of people, under those institutionalized situations. So I want to leave this with you, Mr. Chair. As I said, unfortunately, I was not able to make any copies.

I'll also speak very briefly to some of the challenges as the reality exists in my territory.

I understand there's a gentleman who is five minutes late; maybe I can borrow his time.

Interjections.

Grand Chief Beardy: I understand the act we're talking about was proclaimed in 1984 and that it gave special, unique status to native children and families to recognize our uniqueness as native people, native culture within Ontario. The act made special provision for the apprehension of native children and it gave the band status as a party in legal proceedings concerning a child. The act also provided that before a native child could go to a mainstream foster home, the extended family and other native families had to be considered. Bands do not get funding for the band reps any more. I'm sure you've heard this over and over again. Bands in that situation—I mentioned that it cost me \$3,000 just to be here. Of the communities I represent, 34 of them are remote, and air travel is very costly. So the bands cannot afford lawyers and cannot afford to send band reps to court. Courts are often held hundreds of miles or kilometres from where the child and family and the band are located.

The five-day rule—a hearing within five days—is a major problem for us as well, because First Nation courts are held every three months at best. In most cases, the hearings take place in urban centres. As a result, the child doesn't have any legal representation, the band cannot afford travel and we cannot afford a lawyer to represent the family. So the only person who is there is the children's aid lawyer to make a case, and because nobody could defend our situation, we're left at the total mercy of the courts.

Some of the recommendations—I mentioned earlier the bigger picture, where unless the jurisdiction of First Nations people is recognized and worked toward, I don't see any major change in terms of improvement in quality of life for children in my communities. However, just looking at the act itself, we need to preserve and protect the special status given to native children and families under the 1984 Child and Family Services Act.

1810

Number two is to provide proper funding for children to permit bands to hire lawyers and band reps to advocate for their rights, as promised in the Child and Family Services Act, and to provide proper legal aid funding so that native families can hire lawyers and travel to court.

Number four is to keep the promises made in 1984, when the Child and Family Services Act was proclaimed.

I think number five is important: that there has to be meaningful dialogue and input allowed from us to make sure that what I outlined is not repeated again. I mentioned Ontario's practices. That was only 40 years ago. I know that was before most of the ladies were born, but 40 years ago is not a long time.

That's all I have. Mr. Chair, I'd like to send in my summarized written presentation, if I may, tomorrow.

The Chair: If you please, and if you send it to the clerk's office, she will provide a copy to all of us and it will be part of the record. We'll accept whatever we're going to receive tomorrow.

There are 30 seconds each if you want to ask questions. Could I start with you, Mrs. Munro, please?

Mrs. Munro: I just want to thank you for coming here. We appreciate the distance that you have come and obviously the unique circumstances of the area you represent. I certainly appreciate your coming here to make a submission today.

The Chair: Mr. Hampton.

Mr. Hampton: I just want to know, Stan, how bad are the highways?

Grand Chief Beardy: We don't have highways. We travel by air. I mentioned that 34 of my communities are fly-in. We even get delayed sometimes up there, because when the clouds are really thick, the plane gets slowed down.

The Chair: Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Stan, thank you so much for coming. I just wanted to clarify, because the other groups have talked about section 44 in particular: Is that the section that you're most concerned about, the customary care provisions?

Grand Chief Beardy: No. I think the bigger picture is what I am most concerned about. The message I'm trying to get across here is that we are people too. Prior to Columbus getting lost, we used to look after ourselves and look after our own families. I think the message I'm trying to get across is that we need to work with the province of Ontario to make sure the legislation works for us as well.

The Chair: Thanks very much for your comments and answers.

LONDON DISTRICT CHIEFS COUNCIL

The Chair: The last presentation for the day is the London District Chiefs Council—15 minutes, my friend, this time. You can start any time you're ready. We start minus four minutes, I hear.

Chief Randall Phillips: Yes. Good afternoon again, Chair. Good afternoon, committee members. Hopefully, you'll see the difference between an off-the-cuff speech and a typewritten speech. If I do this, it's not any offence; I just can't see.

My name is Chief Randall Phillips. I'm the elected chief of the Oneida Nation of the Thames. I'm here today representing the London District Chiefs Council, which is comprised of eight First Nations communities in south-western Ontario. We'd like to thank you for adding the extra two days so that we could make this presentation.

We are in the early stages of developing a First Nations child welfare authority. It's called the Mnaasged Child and Family Services. We recently passed our milestone in that organization, as we recently had our first general assembly.

Before I speak on the specific issues raised by the proposed amendments, I'd like to discuss the difficulties we had with that process. In June 2005, the Ontario chiefs in assembly rejected Bill 210 due to lack of consultation with First Nations. This position was formalized in two resolutions that were forwarded to the government. The London District Chiefs Council supports these

resolutions forwarded by the chiefs. We are demanding meaningful consultation on the amendments in a separate, distinct process specifically designed for First Nations.

We take the position that the government of Ontario has a legal obligation to consult with First Nations and take all reasonable efforts to accommodate those rights and interests. This legal duty flows in part from section 35 of the Constitution Act, 1982. Further, it flows from section 2.2 of the 1965 Indian welfare agreement, to which Ontario is a signatory, and this requires First Nations consent before any significant alteration to a welfare program, including a child welfare program, occurs. The provincial government has not lived up to its legal duty to work with First Nations on these key provisions of the bill.

In order for consultations to be meaningful, adequate financial resources must be made available for First Nations to fully participate in the process. This includes resources for professional fees, travel and meeting space. Each First Nation must have the flexibility to decide how they wish to be consulted, whether it be individually, as a member of a tribal council or within their PTO. The costs related to consultations of this magnitude might seem significant at first glance, but the actual cost pales when compared to the human and social costs associated with implementing flawed legislative regimes in our communities.

Notwithstanding our complete and total opposition to Bill 210 itself, we are cautiously optimistic that the perceived shift in the philosophy for child welfare that seems to be outlined in the amendments would make a difference to our children in our communities. The movement in the system toward investing in families and communities contains a strong, positive message. I think you've heard before that our communities have been actively engaged in customary care and this differential response for many years.

We concur with our brothers and sisters who have spoken before us: Customary care is an aboriginal custom, something unique to each nation, and it cannot and must not be treated as a regulatory function controlled by the government of the day. Section 44 of the bill—section 223 of the act—would in effect give the government open-ended regulatory power to define First Nations customary care. This is inconsistent with the spirit of part X of the Child and Family Services Act, and it also affects First Nations rights and interests as it intrudes on First Nations' authority. We strongly recommend that this section be stricken from the amendments contained in the bill.

We are also encouraged by references in the amendments to alternative methods of dispute resolution. While the bill itself leaves the details of the system to be specified through a regulatory regime, we view this philosophical shift in a positive light.

As I noted in my opening remarks, we are at the initial stages of setting up our own child welfare authority in

our region. The children from our communities are still receiving services from non-native societies.

In closing, I'd like to address the third component of the ministry's child welfare transformation agenda—accountability—and discuss the issue of non-native societies who provide services to First Nations children and communities.

As in our region, the majority of First Nations of Ontario receive their child welfare services from non-native agencies, and First Nation children are over-represented in that system. We are not aware of any accountability mechanism by which the ministry ensures that mainstream societies are utilizing the native-specific provisions in the act appropriately.

The research that we have conducted in our region indicates a high degree of use of formal legal intervention in terms of care type and status as opposed to the voluntary care agreements which utilize First Nations extended family placements. This is somewhat confusing, as one of the stated purposes of the act is to ensure that the native children have the opportunity to receive culturally congruent care whenever and wherever possible.

The ministry should take immediate actions to ensure that non-native agencies providing services to aboriginal children, families and communities are being accountable to the native provisions of the act.

On behalf of the 15,000 members of the First Nations of the London District Chiefs Council, I thank you for this opportunity to address the standing committee on this most important issue.

The Chair: There is a minute each for questioning. Ms. Wynne, will you start, please.

1820

Ms. Wynne: Thank you, Randall. Written and unwritten, you're very good. Can you just clarify for me—I understand where you said your position is that there needs to be a meaningful, separate consultation, and I have heard that. But I also wanted to ask you what the ongoing discussion is right now, either internally among the First Nations groups or with the ministry. Can you just clarify for me what the ongoing discussion is?

Chief Phillips: We have established a chiefs committee on child welfare at the Ontario level, through a resolution. Currently, there are representatives from the major PTOs in Ontario—NAN Treaty 3, AIAl, Independent and Union of Ontario Indians—along with representation from the Association of Native Child and Family Services and those unaffiliated communities that don't fall within that process or are stand-alone, like—

Ms. Wynne: And they're having an internal conversation about these issues?

Chief Phillips: We have met with the minister, the parliamentary assistant and her staff to start to discuss the wider issues with respect to child welfare issues, not just 210. Bill 210 precipitated this, but we're trying to use that body and that forum to address all the other issues you've heard today that were raised.

Mrs. Munro: I just wanted to thank you again for providing us with this information. From my perspective,

I think it's a question of waiting to see how the government is going to respond in terms of the kinds of issues that have been raised here, and certainly look at ways by which we could encourage government to move in the directions that are suggested. Thank you.

Chief Phillips: I certainly agree with you, Ms. Munro, that we're all anticipating in which direction the government will move and whether or not they've heard any of the submissions made on this issue.

Mr. Hampton: Just to follow up on the questions that Ms. Wynne asked earlier, it seems to me you've reflected on the issue of Bill 210 and you've pointed out that some things need to be struck from the bill and some amendments might be welcome. But what you're really concerned about is the broader and deeper issue, which the government so far has seemed to miss the boat on, and that trying to patch up 210 is not going to fix or address or deal with the broader and deeper issues that First Nations want the government to start paying attention to.

Chief Phillips: I think my previous presentation, in conjunction with comments made by Chief Stan Beardy, outline that exactly. But this is a wider issue other than a couple of amendments here. What we're talking about is a systematic approach that has had a negative impact on our children, our families and our communities, and that's the issue that needs to be addressed. Although we're taking the opportunity to voice those through this process to deal with one specific piece of legislation, it's a wider picture that we're certainly looking at.

The Chair: Thanks very much for your presentation. We have finished this evening's presentations. I would ask the members of the committee to wait, because we have to decide our next meeting and when we are going to clause-by-clause. Thank you again for coming and making your presentation.

Are there any suggestions from anybody?

Ms. Wynne: Mr. Chair, I just wanted to follow up on my question with the committee. It seems to me that it's really important that we know, as a committee, what the result of those internal conversations is before we move forward with amendments—the conversations that Mr. Phillips was just talking about, those internal discussions among the First Nations. I don't know whether staff or somebody can answer that, but I think we need to know what the result of those conversations is before we accept amendments. Maybe we can just send that comment back to the ministry so that they're aware, or at least—

The Chair: That's fair. I guess what I'm trying to understand is if we wish to move on with clause-by-clause, or do we need more time because we're going to be waiting to get some answers?

Ms. Wynne: My understanding is that the minister has said there will be some sort of dovetailing of those conversations with our amendment process, but I just wanted it to be on the record that that should happen.

Chief Phillips: Mr. Chair, if I could, Grand Chief Denise Stonefish is the chair of our meetings and perhaps would be—

The Chair: OK. Go ahead. I'm sure the members want to hear, so go ahead, please.

Grand Chief Denise Stonefish: Basically, our meetings have been to talk about some of the amendments that Bill 210 is proposing. We've indicated the same information that we've been presenting here. We are looking at a long-term goal in establishing our own native child welfare act, which will be specific to us, because as you heard throughout the hearings here, we're wanting to maintain care and control of our children, which is something we never voluntarily gave up.

Right now, those particular meetings that we're having with the chiefs committee on child welfare and the ministry have been twofold: They've been fact-finding sessions, and it's to inform the minister as to where we're coming from and those types of discussions.

Ms. Wynne: The committee probably won't meet for clause-by-clause until after we come back in January or February. Is there a possibility that we can have some information about your deliberations before we—is that time frame reasonable?

Grand Chief Stonefish: I'm sure we can provide you with some information, with a synopsis of those two particular meetings. The other thing we are looking at too is clause-by-clause of Bill 210, and I'm pretty sure we can also forward that information to you.

Ms. Wynne: OK. I think that timing's very important. Thank you.

The Chair: Thanks very much again for your assistance.

Are there any suggestions when we should meet at this point? Anyone?

Mrs. Munro: I think it would be appropriate to be looking at it from a subcommittee perspective and then present to the committee. It would seem to me that would be when we come back.

The Chair: So we are looking at February.

Ms. Wynne: Does that mean January 16 or does that mean February? Sorry, Julia, I wasn't sure.

Mrs. Munro: Well, the House doesn't come back, I understand, until February.

The Chair: There will be a subcommittee meeting some time in February when we come back and we will decide the date for the clause-by-clause. I think that's what I hear. Any disagreement with that?

Mrs. Munro: And that would fit—obviously from these discussions it would be appropriate, I think.

Grand Chief Stonefish: How's that for speed?

Ms. Wynne: Awesome.

The Chair: Thanks very much. That is all. The meeting is over.

The committee adjourned at 1828.

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Mr. Peter Fonseca (Mississauga East / Mississauga-Est L)

Mr. Jeff Leal (Peterborough L)

Mr. Rosario Marchese (Trinity–Spadina ND)

Mr. Mario G. Racco (Thornhill L)

Mr. Khalil Ramal (London–Fanshawe L)

Ms. Kathleen O. Wynne (Don Valley West / Don Valley-Ouest L)

Substitutions / Membres remplaçants

Mr. Howard Hampton (Kenora–Rainy River ND)

Mrs. Linda Jeffrey (Brampton Centre / Brampton-Centre L)

Mrs. Julia Munro (York North / York-Nord PC)

Also taking part / Autres participants et participantes

Mr. Dave Levac (Brant L)

Clerk / Greffière

Ms. Anne Stokes

Staff / Personnel

Ms. Margaret Drent, research officer
Research and Information Services

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Official Report of Debates (Hansard)

Monday 30 January 2006

Journal des débats (Hansard)

Lundi 30 janvier 2006

**Standing committee on
social policy**

Local Health System
Integration Act, 2006

**Comité permanent de
la politique sociale**

Loi de 2006 sur l'intégration
du système de santé local

Chair: Mario G. Racco
Clerk: Anne Stokes

Président : Mario G. Racco
Greffière : Anne Stokes

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 30 January 2006

Lundi 30 janvier 2006

The committee met at 0902 in committee room 151.

SUBCOMMITTEE REPORT

The Chair (Mr. Mario G. Racco): Good morning and welcome to the meeting of the standing committee on social policy in consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services.

Our first order of business before we commence the public hearing is the motion for the adoption of the subcommittee report. Ms. Wynne, please.

Ms. Kathleen O. Wynne (Don Valley West): Yes, Mr. Chair, the report of the subcommittee:

Your subcommittee considered on Wednesday, December 14, Thursday, December 15, 2005, and Monday, January 16, 2006, the method of proceeding on Bill 36, An Act to provide for the integration of the local system for the delivery of health services, and recommends the following:

(1) That the committee meet for the purpose of public hearings on Bill 36 on Monday, January 30 in Toronto; on Tuesday, January 31 in London; on Wednesday, February 1 in Ottawa; on Thursday, February 2, 2006, in Thunder Bay; and on February 6, 7 and 8 in Toronto. Times and locations are subject to change based on travel logistics.

(2) That an advertisement be placed for one day in all English and French Ontario dailies and weeklies, and also be placed on the ONT.PARL channel, the Legislative Assembly website and in a press release.

(3) That the deadline for those who wish to make an oral presentation on Bill 36 be 5 p.m. on Friday, January 13, 2006.

(4) That after the deadline the clerk will provide the members of the subcommittee with a list of those requesting to appear and locations, so that the subcommittee may make final decisions regarding meeting dates and locations.

(5) That if there are more witnesses wishing to appear than time available, the clerk will provide the subcommittee members with the list of witnesses, and each caucus will then provide the clerk with a prioritized list of witnesses to be scheduled.

(6) That the time allotted to organizations and individuals in which to make their presentations be 15 minutes.

(7) That the deadline for written submissions on Bill 36 be 5 p.m. on the second day following the last public hearing.

(8) That the research officer provide the committee with a summary of witness presentations prior to clause-by-clause consideration of the bill.

(9) That amendments to Bill 36 should be received by the clerk of the committee by 5 p.m. on Thursday, February 9, 2006.

(10) That the committee meet for the purpose of clause-by-clause consideration of Bill 36 on Monday, February 13 and Tuesday, February 14, 2006, in Toronto.

(11) That the minister be invited to speak to the committee for 15 minutes on the first day of public hearings.

(12) That options for videoconferencing or teleconferencing be made available to witnesses where reasonable.

(13) That requests for reimbursement of travel expenses for witnesses to attend hearings be subject to approval by the subcommittee.

(14) That the clerk of the committee, in consultation with the Chair, be authorized to commence making any preliminary arrangements to facilitate the committee's proceedings.

The Chair: Thank you. Any debate on the motion? None. Therefore, I will take a vote.

All in favour? Those opposed? It carries.

Ms. Wynne: Mr. Chair, I'd like to move another motion on an item of business: Bill 210.

I need to move that we meet for the purpose of clause-by-clause on Wednesday, February 15, and that we request that the House leaders give us permission to sit on that day.

The Chair: Any comments on the motion? We also need to know the deadline for amendments.

Ms. Wynne: So if the clause-by-clause is on Wednesday, the 15th, would we be asking for amendments the Friday before?

The Chair: Mr. Arnott.

Mr. Ted Arnott (Waterloo-Wellington): Mr. Chair, I've received no prior notice of this motion coming forward. I think it would have been an appropriate courtesy, perhaps, to share with the opposition the rationale before moving the motion. I would just like to ask Ms. Wynne to explain to the committee why it's necessary to move this motion at this time.

Ms. Wynne: It's necessary to move this motion. We had talked about considering clause-by-clause of Bill 210 that week, but because Bill 210 and Bill 36 are coming at the same time—we have no permission in this committee to sit on a Wednesday; we only have permission to sit on Monday and Tuesday—so we need the House leaders' permission to do that. That's why I'm bringing the motion. It had always been the intention to consider the bill that week.

Mr. Arnott: And the date, again, that you're suggesting?

Ms. Wynne: Wednesday, February 15.

The Chair: Madame Martel, please.

Ms. Shelley Martel (Nickel Belt): Mr. Chair, I'm subbing in on this committee, and I don't sit on the committee when it deals with Bill 210, so do I have some assurance that the other party members who sit are aware of this, know that the motion was coming and agree to it?

Ms. Wynne: My understanding is that that is the case. That's what I've been told. If you'd like to wait until later in the day to finalize this, I'd like to put the motion on the floor, and perhaps we could vote on it later. Is that okay?

The Chair: Any other comments? Are we in favour of dealing with the matter now, or should we defer it for later on?

Mr. Arnott: I prefer that it be stood down until later in the day.

The Chair: Fine. Thank you.

LOCAL HEALTH SYSTEM INTEGRATION ACT, 2006

LOI DE 2006 SUR L'INTÉGRATION DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair: At this time, it's a pleasure to have the minister joining us and giving his opening remarks. Welcome, Minister.

Hon. George Smitherman (Minister of Health and Long-Term Care): Thank you very much. Good morning. It's a great privilege for me to be here to address this committee on the first day of public hearings on Bill 36, the Local Health System Integration Act.

This piece of legislation is very important to me. It's very important to our government, and above all, it is important to the more than 12 million Ontarians who depend on the health care system that this bill is reshaping. Reshaping, fundamentally changing, improving: That's what we set out to do with Ontario's health care system with this bill. It's a tall order, and it's a daunting one, particularly when you consider the consequences of

not getting it right, which is why I'm so grateful for the work that you're undertaking here today.

Mr. Chair, we have a good team on hand to assist your committee's work. Kathleen Wynne is here to help work this bill through committee, alongside my legislative assistant, Dan Carbin, as well as a ministry team led by Tracey Mill, director of the LHIN project team.

It sometimes seems a shame to me that when it comes to the work that we do here at Queen's Park, so much media and public attention is focused on question period—actually, some days that seems a lot worse than just being a shame—because as important as that work is, it's not remotely the best of what we do. This is. Every bill that I've had the privilege of bringing forward as Minister of Health and Long-Term Care has been subsequently improved during the committee process, and I'm quite certain that this one will be as well. I'll be disappointed if it's not.

I know, for example, that concerns have been raised about the legislation not doing a good enough job meeting the unique needs of our francophone and aboriginal communities. I've reviewed the reports commissioned by my ministry—the First Nations task force, the Metis report, the francophone report—and I'm eager to hear more during these seven days of hearings. The constitutional rights of aboriginal people and our government-to-government relationship must be recognized. The requirements of the French Language Services Act are equally clear with respect to our francophone community. So I look forward to these hearings and the work that is going to get done.

This is a tough process, but it's a critical one—or maybe I should say a critical process, but a useful one—because at the end of the day it is about making sure that we pass the very best piece of legislation that we can, legislation that actually does what it sets out to do, which is to place patients squarely at the centre of the health care system. That really is what it is all about: establishing a new kind of conversation in health care, one that involves patients instead of excluding them.

We set out to craft a piece of legislation that would ensure that many of the absolutely critical decisions that are made about health care in this province are made closer to the action, by people who are closer to the action in the communities, where the impact of those decisions will be felt, after consultation with the people who will feel their effect and with input from people who actually do the work.

We set out to craft a piece of legislation that would ensure that decisions would be taken in a transparent and accountable manner, based on priorities set in communities and taken at open, public meetings. In an environment where we all agree that there will be fewer resources than we might prefer, it's just common sense that we ask people from local communities, closer to the action, to help determine which local priorities must be supported first.

0910

We set out to craft a piece of legislation that would allow the Ministry of Health and Long-Term Care to rise

up to a more strategic level, plotting the overall direction of health care in this province and leaving the day-to-day negotiation of the twists and turns to people closer to the ground. That's what we set out to do. I think we did a pretty good job, and I'm looking forward to your help in making it even better.

I want to take a moment to talk about the nature of change, because change is at the heart of what we're going to be discussing here today and over your deliberations.

There's no question about it: Bill 36, the Local Health System Integration Act, represents a pretty radical change for a system that has been too comfortable with the status quo for too long. I'm not going to be coy about this. We're changing things. We're proposing to devolve significant power and authority from Queen's Park to people at the community level through 14 organizations that didn't exist one year ago. We want to give these organizations control of more than half of the health care budget in this province—a whopping \$21 billion. We want to align and reduce the number of community care access centres from 42 to 14 and return control of the CCACs to the communities they came from.

We've closed district health councils, and we're closing regional offices. We are putting like functions under one roof, for once. We're redesigning the health care system in this province because patients have told us that the status quo simply isn't cutting it. We are changing things, and change is hard. That's a simple little saying, but it's very, very true. Change is hard, and we recognize that.

A very great deal of what I expect this committee will be hearing over the next few days of hearings is reflective of that simple fact. Change is hard, and many people resist it out of pure reflex.

I want to be clear. I'm not minimizing the concerns that people might have, but that does not excuse what we have seen in the two months since our government introduced Bill 36, which is an organized campaign of attacks that are often baseless, poorly researched and appear to be driven simply by the desire to provoke fear.

I fully expect many of these attacks to be repeated before this committee, and I would urge my colleagues to examine them carefully, to distinguish between what is valid criticism and what is deliberate misinformation and simply the folly of those with too vivid an imagination. Above all, I would urge you to ask the simple, critical questions: "Where does the bill do that? Where in the bill does it say that?" If you do, I predict that you will, to torture an old expression, find a lot more chaff than you do wheat.

I'd like to spend the rest of my time here today talking about that. I want to examine some of the attacks that have been manufactured and then levelled at this legislation. Baseless attacks and deliberate misinformation are harmful to this process and a threat to what we're really trying to do, and they must be exposed as such.

Let me predict, if I may, a few of the things you're going to hear as you conduct these hearings. Example:

Local health integration networks are going to open the door to privatization and to two-tier health care. Really? I've read Bill 36 very carefully. Not only does it not say that, in fact it specifically prohibits any integration that would result in an individual being required to pay for a health service, and also affirms our government's commitment to publicly funded medicare.

I also recall another piece of legislation that our government passed: Bill 8, the Commitment to the Future of Medicare Act. That bill made two-tier, pay-your-way-to-the-front-of-the-line health care illegal, and enshrined in law the principle of publicly funded medicare.

The simple fact is, our government defines itself by its commitment to a strong, equitable, publicly funded health care system. We have proven this with our actions, and nothing in Bill 36 should give anyone reason to doubt that commitment.

Let me move on to another oft-repeated attack: Local health integration networks are going to close hospitals. No, they're not. The legislation clearly states that they can't; only the minister can, and that hasn't changed. But this minister is standing before you to say, as I have said many times, that not a single hospital is going to close on our watch. Period.

I might also add, for the conspiracy theorists who insist that this government's secret, wicked dream is to cut hospital services, that it was surely a little odd of us, then, to provide hospitals with stable multi-year funding increases that will total more than \$1 billion over the next two years.

Here's another: Local health integration networks are going to extend the competitive bidding model to the entire public health care system. Well, I don't want to seem repetitive, but I'm holding the bill right here—although I'm not—and, as I've said, I have read it many times. Folks, it doesn't say that anywhere—not anywhere.

Local health integration networks are designed to better manage and coordinate health care services in order to ensure better access to those services. That does not mean competitive bidding, but it does most certainly mean that we believe we can do a better job of integrating the various health care services, to the benefit of patients.

Moving on: Another thing we've heard is that there has been no consultation about local health integration networks. First off, nobody can pretend that this initiative came out of the blue. We signalled our intentions in this regard within four months of forming government, and in February 2004 we announced the development of this made-in-Ontario solution. Since then, we've held a vast array of public meetings and working sessions attended by more than 6,000 people. Representatives of patient advocacy and community groups, unions, health care providers and health-related associations have all helped to shape the development of local health integration networks. This is a made-in-Ontario plan and it is very much a made-by-Ontario plan.

Another charge: Local health integration networks will result in patients having to travel further for services.

Let's be very honest. The facts are well established. Clinical outcomes are simply better when they are provided in an environment where more of them are done. Pretend if you wish, but it is simply unrealistic to think that we can provide comprehensive first-class acute health care on every street corner of this province. What we can do, and what LHINs will do, is to make decisions about health care in local communities based on input from patients, providers and the public at open meetings and through extensive consultation. Any decision to consolidate a service must be made in the public interest.

Notwithstanding the fear factor campaign, our government believes that a population health model of health care planning will lead to a repatriation of services; for example, satellite dialysis. Ask the people from Bancroft, Moose Factory or Woodstock. They know. They're not travelling any more to access those services.

Our critics also charge that local health integration networks will mean lost jobs and lower wages. They are ignoring, it seems to me, the basic fact that health care spending is only going one way, and that's up, and that 80% of health care funding is in fact spent on human resources. Presumably, if our intention was to slash and burn, we would not be continuing to invest billions of new dollars in health care—but we are.

Our critics point to the recently announced plan to close our seven regional offices as proof that jobs will be lost. But aren't these the same people who very recently said that local health integration networks were simply a new layer of bureaucracy? It is true that with the closing of those offices, some jobs may be lost. But new and different opportunities within local health integration networks, the ministry and the broader health care sector abound for talented and experienced people.

Those wedded to the status quo are ignoring the fact that for Ontario patients the status quo was not getting the job done in a timely way. For decades we've heard that the silo mentality of the Ministry of Health was impairing patients' ability to seamlessly experience what we all refer to as the proper continuum of care. We're toppling the silos and creating a new dynamic for planning and decision-making closer to the action, where the patient has a place in the conversation. That is the integration that we seek.

Finally, and really of all the myths being perpetrated by critics of local health integration networks, this might be my favourite: that local health integration networks are not responsive to the needs of communities. If there is one thing—just one thing—that you need to know about local health integration networks, it's that we created them specifically in order to make health care more responsive to the needs of the community. I spoke about this at the outset. This is what local health integration networks are all about.

Pretend if you want, but you cannot appropriately micromanage a \$33-billion operation from head office. So we're building a system where critical health care decisions will be made at the local level, by local people who understand the needs of the community and in many

cases probably know by name many of the patients being affected by those decisions.

You know that we're not inventing the wheel here, although I like to think we're improving it. Every other jurisdiction in Canada has introduced some form of regionalization in health care, a model that Roy Romanow has been calling for for years, and he wasn't alone. As long ago as 1996, the Ontario Nurses' Association published *Vision for Saving Medicare*, which involved—get ready for it—an integrated delivery system. It called for a system that “provides high-quality, appropriate, consumer-oriented, outcomes-based and cost-effective services within ... locally created system structures designed to meet each community's unique needs.” I couldn't have said it better myself.

0920

Now, all of the pretend arguments aside, I want to repeat something that I said at the outset: I am not out to minimize people's legitimate concerns. These hearings are all about examining the bill to see where it can be made better, and I look forward to hearing from this committee and to working with all of you to make Bill 36 deliver on its promise: the promise of a true system where the patient is at the centre of the discussion and the discussion takes place at the centre of the community. Thank you.

The Chair: Thank you, Minister. I'm sure your comments will assist us in providing answers to the deputants. Could we have a copy of your speech so that the clerk will be able to provide all of us a copy? Thank you again.

We'll move on to the presentations.

CARDIAC CARE NETWORK OF ONTARIO

The Chair: The first presentation after the minister is the Cardiac Care Network of Ontario. Dr. Kevin Glasgow, Dr. Eric Cohen and Jane De Jong, please. You can start any time. You do have 15 minutes total. If you don't use it all, we might be able to ask some questions of you.

Dr. Kevin Glasgow: Thank you for this opportunity to provide comments on Bill 36. For many years, the Cardiac Care Network of Ontario has advocated for health system integration and an end to silo-based cardiac planning. We are extremely encouraged that the LHIN legislation provides opportunities to improve access to care, service quality, system efficiencies and outcomes for Ontario's cardiac patients and their families. But more is required to enable a truly system-wide integrated approach to cardiac services.

My name is Kevin Glasgow. I am CEO of the Cardiac Care Network of Ontario and I am a public health physician and medical officer of health by background. I believe very much in connecting prevention to treatment, to rehabilitation. I'm accompanied by Dr. Eric Cohen, who is a practising cardiologist at Sunnybrook and Women's College Health Sciences Centre as well as being CCN's medical officer.

By way of background, CCN is a non-share capital corporation funded by the ministry. We operate North America's largest population-based cardiac registry and integrated wait list monitoring and management system. We're also an advisory body to the ministry, well-known for our consensus panel reports. A copy of CCN's objects is attached as schedule A.

CCN is a national and international leader in facilitating timely and equitable access to care. We do this on a province-wide basis for selected cardiac procedures, specifically cardiac surgery, coronary angioplasty and cardiac catheterization. In conjunction with our 17 member hospitals and our regionally based cardiac care coordinators, more than 85,000 patients per year benefit from CCN's: clinical urgency rankings; maximum wait time guidelines; monitoring while on the wait list; and patient management to ensure that the most urgent patients receive priority access to care.

For more than a decade, CCN has publicly reported wait times by cardiac hospital, and we provide on a monthly basis detailed reports to clinicians, hospitals and the ministry. Through our collective efforts and with the support of successive governments since 1990, cardiac procedure wait times have been substantially reduced and equity and access improved.

In light of these important accomplishments for Ontarians, why are we here today? CCN has two major issues which we ask the committee to address in reviewing Bill 36. The first issue is the critical need to ensure that there is inter-LHIN coordination in cardiac care and other province-wide health matters. We cannot afford to retain a silo-based approach to matters in which there are or should be provincial standards and strategies. CCN suggests solutions to this, including (a) amplifying the objects of each LHIN with respect to inter-LHIN coordination; and (b) ensuring that each LHIN works with agencies, health care registries and other persons with a ministry-endorsed provincial mandate such as the Cardiac Care Network.

The second issue is the vital need, mandated through legislation, to develop a comprehensive and integrated pan-provincial cardiac strategy that will improve the health of Ontarians through better access to cardiac services via the effective and efficient management of the health care system. CCN is prepared and positioned to take on this essential role of developing a provincial cardiac strategy.

In our written submission, we have proposed legislative amendments to address these two issues, and we respectfully request the committee's consideration of these proposals. In order to stay within our time allocation, we will not talk about the details. We will, however, speak to two overriding issues.

Firstly, inter-LHIN coordination: LHINs offer the opportunity to address access, quality, outcomes and efficiency across the continuum of care for cardiac and other disease areas. To most appropriately address these issues, the LHIN legislation and its regulations need to facilitate an overarching planning and coordinating mechanism that ensures that Ontarians in all 14 LHINs

are equitably served. There must be pan-provincial standards that apply to all 14 LHINs, and an umbrella monitoring and assistance set-up that ensures compliance with these standards. We must ensure that this legislation does not result in the creation of 14 new silos that reinvent the wheel and that do not efficiently interact with one another.

In the case of specialized cardiac services, such inter-LHIN coordination is particularly vital. Two of the 14 LHINs currently lack a cardiac catheterization lab; five of the 14 LHINs do not contain a cardiac surgery centre; and four of the LHINs do not contain an angioplasty centre. Furthermore, the LHIN boundaries in many areas of the province do not correspond to natural patient movement and referral patterns. Therefore, inter-LHIN coordination is vital to ensure equitable access to cardiac services and, given finite health care dollars, to ensure most efficient use of current resources.

Our second overarching issue is that of provincial cardiac strategy. Due to CCN's historical mandate, which limits our interaction with other providers and planners of the health care system, what CCN does on its own is far from adequate in addressing the overall needs of cardiac patients. From an access to care perspective, only revascularization-related procedures—that is, surgery, angioplasty and cardiac cath.—are tracked electronically in the province's cardiac registry. The advent of LHINs is an opportunity to look at systematically monitoring and promoting access to care and other procedures such as arrhythmia procedures and, just as importantly, access to non-procedure activities such as cardiac rehab, downstream, and prevention programs, upstream.

CCN is committed to the need for a provincial cardiac strategy. This is essential to guide the activities of LHINs. Ontario has a provincial stroke strategy and a provincial cancer plan, but, despite the fact that cardiovascular disease is the number one cause of death in our society and the fact that many billions of taxpayers' dollars are spent every year on addressing various facets of cardiovascular disease, there is no provincial co-ordinating integrated strategy. Provincially, prevention is not well connected with treatment, which is not well connected to rehabilitation. While there is broad language in Bill 36 that alludes to three-year LHIN strategic plans being in place by the end of this year, we must ensure that the appropriate structures are put in place to bridge the LHINs from the onset.

The Cardiac Care Network of Ontario is ready, able and willing to take on a broader role in the promotion and monitoring of access, the assurance of quality service delivery, the examination of health outcomes and the efficient use of resources. We have a demonstrated, internationally acknowledged track record of success in those activities for which we have been given a ministry mandate. It is time to develop a provincial cardiac strategy and apply our learnings across the continuum of cardiac care, working in conjunction with other sectoral leaders, in the interests of better serving Ontarians. CCN is positioned to take on this role in conjunction with other sectoral leaders.

By way of summary of our proposed legislative amendments, they are as follows and are set out in detail in schedule B.

(1) Add a new object for LHINs to ensure inter-LHIN coordination, and amend the objects such that LHINs are obliged to work together with province-wide organizations.

(2) The minister should consult with province-wide organizations to ensure that the provincial strategic plan is comprehensive and reflects the best expertise possible.

(3) There should be a specific obligation for LHINs to consult with province-wide organizations in order to ensure that LHINs have common approaches in areas in which there should be provincial standards. In the cardiac context, for example, it will be important to ensure that all LHINs have common cardiac priorities particularly with regard to access standards; for example, maximum wait times.

(4) Require health service providers to work with province-wide organizations to identify opportunities for integration.

(5) Require LHIN accountability agreements to be consistent with agreements between the ministry and province-wide organizations.

(6) Require service accountability agreements to be consistent with agreements between the minister and province-wide organizations.

(7) Each LHIN should include within its integrated health service plan priorities and strategic directions that reflect those set by CCN and which are in accordance with the provincial strategic plan.

(8) Bill 36 should include a requirement for a provincial cardiac strategy.

0930

By way of concluding remarks, CCN recommends that the legislation be amended to clarify the needs and mechanisms for inter-LHIN coordination in matters of provincial standards, and to include within the LHIN legislation the requirement for a provincial cardiac strategy.

You have the opportunity to optimally shape inter-LHIN coordination and provincial standards for cardiac care in Bill 36 and its associated regulations. The Cardiac Care Network of Ontario can be leveraged in your efforts, and we request your legislative support for our proposals. Our mission is similar to that of the Ontario government and of every LHIN: to ensure prompt and appropriate access to care for all Ontarians. These proposals are intended to better serve patients and most effectively utilize finite health care resources.

Thank you for your attention. We would be pleased to address questions.

The Chair: Thank you. There are about three minutes, so one minute each. Mr. Arnott, please.

Mr. Arnott: Thank you very much for your presentation. It's very thorough, very detailed. You're the very first presentation in the course of these hearings, so I'm sure everyone on the government side is very attentive to what you've suggested. Also, your suggestions on amendments are very specific and detailed. For our part,

we'll be studying them carefully and hoping to be in a position to bring them forward to ensure that the bill is refined to reflect the needs of patients, cardiac patients in particular, in the province of Ontario. Thank you very much.

The Chair: Madame Martel.

Ms. Martel: I don't have any questions, Mr. Chair.

Thank you very much for your presentation.

The Chair: Ms. Wynne, you have a minute or so.

Ms. Wynne: I want to thank you for the specificity of your document.

I had a question. In schedule B, your amendment to the objects, number 5(h), you talk about "agencies, health care registries and other persons with a ministry-endorsed provincial mandate such as Cardiac Care Network...." I take your point about provincial organizations and the need for coordination. You will recognize, I think, the issue of there being a number of provincial organizations. So what you're looking for is a mechanism or some overt statement of the need to coordinate with the provincial organizations. If we didn't name those provincial organizations, for fear of in the future leaving one out, could you live with that?

Dr. Glasgow: Yes, we could. Clearly, we would prefer to be named, but the intent is to reflect the meaning, such as you have conveyed. So that would be satisfactory.

Ms. Wynne: Okay. Thank you.

The Chair: Thank you very much for your presentation.

ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

The Chair: We'll move on to the next presentation from the Ontario Association of Non-Profit Homes and Services for Seniors. Donna Rubin, please. Ms. Rubin, you have 15 minutes' total. With any time left, there is an opportunity for questions or comments. Thank you. You can start any time you are ready, please.

Ms. Donna Rubin: Thank you, Mr. Chairman. Good morning. I'm Donna Rubin, CEO of the Ontario Association of Non-Profit Homes and Services for Seniors, known as OANHSS. With me today is Margaret Ringland, director of member relations at OANHSS. We are a provincial association with over 350 member organizations across the province. They include municipal and charitable long-term-care homes, non-profit nursing homes, seniors' housing and community service agencies. In total, we represent over 26,000 long-term-care beds and well over 5,000 seniors' housing units. All OANHSS members deliver services on a not-for-profit basis.

I will be focusing my remarks today specifically on the impact of Bill 36 on the not-for-profit long-term-care sector in Ontario.

We applaud this government's bold drive towards a more efficient, coordinated and responsive health care

system with the creation of local health integration networks, or LHINs. From the outset, our members have supported this initiative and have committed to playing an active role in the transition process. If passed, Bill 36 effectively moves health care transformation from rhetoric to action. This legislation sets out the ground rules, clearly identifying the power and authority of both LHINs and the Minister of Health and Long-Term Care.

As the legislative process has unfolded, our priority has been to make certain that the new system ensures the continuation of a strong, viable not-for-profit sector, preserves governance at the local level and respects consumer choice.

In reviewing Bill 36 as it has been tabled, we have some very serious concerns.

Certain aspects of this legislation not only jeopardize the future of not-for-profit long-term care in Ontario but also blatantly discriminate against not-for-profits and could have the unintended result of increasing private, for-profit care in our sector.

Not-for-profit long-term-care providers have a long history of leadership in providing integrated services. Many offer a continuum of service for people with varying levels of need. For example, these homes often function as service hubs for day programs and for Meals on Wheels for seniors living in the community.

As well, not-for-profit homes have a long history of serving their communities and delivering added value. Many reinvest their surplus dollars to enhance and expand the level of service provided to residents. Not-for-profits typically contribute additional resources beyond what the province provides, topping up provincial funding with charitable donations and municipal transfers.

Not-for-profits are deeply rooted in the cultural, religious and geographic communities they serve. They are actively supported by local volunteers and they are sensitive to local needs.

For all these reasons, we believe government should be doing everything it can to ensure that the not-for-profit sector is protected and supported. Bill 36, if passed into law, will do just the opposite by giving unfair advantage to for-profit operators.

Of greatest concern is subsection 28(1), which gives the Minister of Health and Long-Term Care sweeping powers over not-for-profit health service providers, including the authority to force integration, closures and mergers. More specifically, this section gives the minister the authority to change the scope of services of a not-for-profit health service provider, transfer the property of one provider to another, and even close a public facility. Inexplicably, the bill gives no such powers to the minister in the for-profit sector.

This clearly is open discrimination and places the not-for-profit long-term-care sector at a serious disadvantage. To appreciate our concern you need to understand the unique environment in which long-term care operates in Ontario. Ours is the only sector where the government directly funds and regulates both for-profit and not-for-

profit providers to deliver health care. To be clear, basically the same funding formula is used for all 600 homes in the province, regardless of whether they function on a not-for-profit or for-profit basis. Ever since 1993, when the homes for the aged were brought under the Ministry of Health, which already funded and regulated nursing homes, the regulatory framework for the two sectors has been identical. The section 28 exemption of for-profit operators from ministerial action, therefore, is contrary to over a decade of public policy and poses a very real threat to the future sustainability of not-for-profit long-term care in this province.

As an example of how this could play out, consider a situation where the government determines that an area that currently has two long-term-care homes, one for-profit and one not-for-profit, requires only one home. The not-for-profit home would most certainly be the target of a section 28 action since the for-profit operator would be protected from the minister's authority to force a closure. For a government that once was resolute and vocal in its opposition to private, for-profit health care, Bill 36 appears to be a fundamental policy reversal.

The potential consequences of Section 28 are significant. From a financial perspective, not-for-profit long-term-care homes enter into mortgages and other financing obligations. Section 28 creates the risk that they may be closed, merged or amalgamated through unilateral and unchallengeable action by the minister. That risk will be reflected in higher costs for debt financing, increased difficulty in obtaining long-term financing and more difficulty in generating charitable donations.

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From a governance perspective, section 28, and section 26 for that matter, set up a conflict with the role of a governing body of a not-for-profit health service provider to manage the business and affairs of the organization in the organization's best interests. The government can force action on an organization against the wishes of the governing body, and the governing body has no recourse whatsoever. Incidentally, we find it remarkable that there are multiple sections in Bill 36 to indemnify and hold harmless the LHIN boards and executives, and the minister, for whatever actions they take, but nothing similar for boards of directors and executives of health service providers that are in the position of doing whatever the LHINs and the minister tell them to do. Considerations such as these will make it much more difficult for not-for-profit organizations to recruit and retain directors. Questions of liability will ultimately arise, particularly if LHINs impose actions that directors oppose. This legislation may undermine the spirit of volunteerism that has been fundamental to the fabric of our society. The contributions of a vibrant voluntary sector will be severely hampered if every significant decision for an organization in future will be made by the LHIN.

For consumers it will mean a reduction in health service delivery by not-for-profits, and the smaller, more vulnerable organizations are most at risk. Smaller

organizations offer a valuable contribution as they often meet special population needs, are in smaller communities and can be flexible and responsive to emerging needs. Ultimately, consumer choice will be reduced.

Section 28 also calls into question the legitimacy of the government's integration efforts as they pertain to long-term care if the government doesn't have the authority to deal with the entire sector in the same way. For-profits operate over 39,000 of the province's 75,000 long-term-care beds in Ontario. To what extent will the government truly achieve integration if for-profits are excluded?

Good public policy is based on the public interest, and we would strongly suggest to you that it is not in the interests of the public to erode the not-for-profit sector, which is what Bill 36 has the potential to do. We cannot fathom how the public interest could possibly be served by exempting for-profit organizations in section 28. Quite frankly, if for-profit providers choose to operate in the publicly funded health care system, they should be under the same rules as everyone else.

The government has stated, "The proposed legislation does not provide for more privatization." On the contrary: By virtue of the fact that section 28 excludes for-profit operators, Bill 36 very clearly opens the door to increased privatization in the delivery of long-term care.

As I noted earlier, for-profit providers now operate more long-term-care beds in Ontario than not-for-profit providers. This preponderance of for-profit beds is a fairly recent development, with the shift occurring over the last six years, when more than 65% of the 20,000 new beds were awarded to the for-profit sector. Bill 36 could further tilt the balance, leading to further erosion of not-for-profit care and increased privatization of service delivery.

OANHSS is calling on this government to either remove section 28 from the bill or apply it to all providers so that there is no discrimination, so that long-term-care delivery does not become dominated by private operators and so that consumers continue to have meaningful choices for care and services. To do otherwise will not only threaten the future of the not-for-profit sector; it will ultimately not be in the interests of Ontarians.

Thank you for allowing me to present our comments. We will be providing a more fulsome written submission by the February deadline.

The Chair: Thank you for your presentation. We have two minutes left; one each. Madame Martel, will you start, please.

Ms. Martel: Thank you, both of you, for being here this morning. I know you were here for the minister's comments when he talked about some of the people who are levelling criticisms at this bill. He said, "Baseless attacks and deliberate misinformation are harmful to this process and a threat to what we're really trying to do, and they must be exposed as such." And his first baseless attack was that LHINs "are going to open the door to privatization and to two-tier health care."

I don't consider your criticisms, your comments here today to be baseless or deliberate misinformation. Section 28 is very clear in the bill: It doesn't apply to the for-profit sector; it allows the minister essentially to shut down, transfer assets, amalgamate, disintegrate not-for-profit providers.

Do you have any comments with respect to what the minister had to say about your concerns that this will increase privatization?

Ms. Rubin: Well, our sector is the only one where there is this dynamic of the two providers, for-profit and not-for profit, currently in the system, so to us it's very clear. While we have reassurances that it may not be their intent to look to our sector, it certainly is very clear, in black and white, in the bill. We have to bring that up as an issue, and as governments change or different players are in positions, it raises a significant concern for our sector.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for your presentation. I certainly take your point about the unique dynamic in your sector, but I think the word that the minister used, as opposed to the word that you're using in your presentation—he talked about patients and you're talking about consumers. I think what's really important is that the minister, as the steward of the public good, needs to have—if we're going to transform the system the way it needs to be transformed—that ability to take organizations through this transformation. That's why the mechanism is there.

The other thing that's important to know about this bill is that it would also allow LHINs to transfer funds from for-profits to not-for profits. That possibility is there.

The question I'd like to ask you is, do you think it's reasonable for the minister to have mechanisms in place to guard the public good by performing these transformative integrations?

Ms. Rubin: I think that if he wants to make the kinds of sweeping changes he wishes to make, he needs to be able to go as far as he can. But if he's only going to be able to do it on a small part of the sector and be excluded from looking at the—as I say, there are 39,000 beds delivered by the private sector. Then he's only able to integrate, amalgamate or close our homes. I think that's not in the public good.

The Chair: Madame Witmer, please.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): We just heard Ms. Wynne say that this bill does give the minister the power to transfer resources from the profit to the not-for-profit sector. Did you find that in the bill here somewhere?

Ms. Rubin: I think you meant from the private to the—

Mrs. Witmer: From the private; yes.

Ms. Rubin: No, we did not see that at all, but we see that there's the ability to transfer property from a not-for-profit that is being closed down, integrated or merged to another entity, and that's very concerning.

Mrs. Witmer: Did you have any input into this bill? The minister says there was lots of consultation.

Mrs. Rubin: We were able to provide comments, and there have been technical briefings where we were told quite candidly that our concerns are valid. That's what will happen.

The Chair: Thank you very much for your presentation.

REGISTERED PRACTICAL NURSES ASSOCIATION OF ONTARIO

The Chair: We will go to the next presentation, from the Registered Practical Nurses Association of Ontario. Joanne Young Evans, please. You can start any time.

Ms. Joanne Young Evans: Thank you very much. Good morning. My name is Joanne Young Evans. I'm the executive director of the Registered Practical Nurses Association of Ontario. Joining me this morning is Don Gracey.

I would like to thank the committee for giving the RPNAO an opportunity to provide our thoughts regarding Bill 36. This is a very important piece of legislation in that it directly involves the delivery of health care services in Ontario. As a result, it is critical that it receive a thorough review and scrutiny from all stakeholders involved, whether they be from the government, the associations representing health care professionals or the consumers of health care services.

I believe you have in front of you a copy of RPNAO's written submission. I would like to briefly highlight some of the points outlined in the submission this morning, and hopefully I'll leave plenty of time for more detailed questions for Don and myself.

Let me first say that the RPNAO applauds Minister Smitherman for tabling Bill 36. The RPNAO believes that any legislation or initiative by the ministry or the government that has the overall objective of improving the delivery of health care systems in our province is not an easy task and should be commended. The RPNAO supports a more community-based health care delivery system which will improve access to health care services based on the needs and requirements of the individual communities and regions.

While we support a more decentralized approach to health care service delivery, our association is somewhat alarmed at the thought of having to deal with 14 different bureaucracies spread across the province rather than one central ministry. The time, cost and organization necessitated by the need to communicate with all 14 regional LHIN boards is something that our association is not looking forward to. As it probably is for all of the smaller associations, our biggest fear and worry is that we will simply be unable to get our message and communication out to each LHIN board and, as a result, the professions that we represent will be phased out in favour of the larger professions.

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However, if Ontario is to move to a more decentralized, community-based approach to the delivery of health care services, it will be incumbent on us as an association to address those challenges and deal with them as best we can. I simply want to warn that a decentralized approach is always more susceptible to co-optation, if I can put it that way, than a centralized approach.

With regard to the specifics of Bill 36, the RPNAO has serious concerns with a number of the provisions. To be more precise, we feel that Bill 36, as it is currently written, does not accomplish the goal of providing for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care and effective and efficient management of the health system at the local level, as the preamble of the bill suggests. Rather, the RPNAO strongly believes that, in practice, Bill 36 will not realize the positive potential of the LHINs. We have outlined in our submission a number of reasons why we believe this to be so, and I'd like to discuss a couple of those reasons now.

First and foremost, contrary to the intent of Bill 36, it does not give effective decision-making powers to the community, but rather keeps the vast majority of the powers at the ministry level. But at the same time, the bill shifts all accountability to the LHIN. While Bill 36 establishes a number of powers for the LHIN, such as providing or changing funding to a health service provider and facilitating and negotiating the integrations of persons, entities or services between health service providers and a non-health service provider, the minister still retains ultimate control of each LHIN. For example, the minister has the power to unilaterally impose an accountability agreement upon LHINs; bylaws developed by each LHIN may be required to receive ministerial approval; and the minister has the power to appoint members of each LHIN board, the board chairs and vice-chairs. Furthermore, Bill 36 also proposes a number of areas where cabinet approval is also required for a host of LHIN activities.

The RPNAO fully recognizes that there has to be reasonable ministerial accountability and responsibility, particularly with respect to the disbursement of funds to each LHIN and subsequently to each health service provider within each LHIN. However, if all the control mechanisms proposed in Bill 36 are exercised, local responsibility, initiative and community decision-making authority will simply be an illusion.

Bill 36 goes far beyond what is reasonable and necessary in terms of control and grants the government and the ministry greater powers than existed before Bill 36, all the while conveying the illusion of local autonomy and accountability.

Another concern we have with Bill 36 is that we fear it will provide an entree for the expansion of managed competition and privatization in the health care system. A number of stakeholders have publicly expressed similar worries, and the RPNAO concurs. There are valid concerns that in their quest for efficient delivery of health

care services, LHINs will expand the CCAC model of managed competition which has been so destructive of quality care, practitioner continuity and reasonable remuneration in the home care sector.

You have just heard from the association representing non-profit, long-term care, which quite ably expressed its members' concerns that Bill 36 discriminates against the not-for-profit sector while favouring the for-profit sector. We completely concur with those sentiments.

The RPNAO feels that subsection 28(1) establishes both an anomaly and a dangerous precedent by granting special status for for-profit health care providers within a publicly funded system. The for-profit exemption in subsection 28(1) would mean that not-for-profits will more frequently become targets for dissolution or amalgamation, even though in some cases the community would be better served through section 28 orders involving for-profit providers.

Furthermore, the statutory exclusion of for-profit providers for the purposes of section 28 of the bill, when added to the exclusion of physicians, podiatrists, dentists, family health teams, IHFs, medical laboratories and public health, seriously limits Bill 36's ability to achieve its integration objectives.

We understand that the LHIN jurisdiction applies only to approximately \$20 billion of the ministry's total expenditures of around \$35 billion—less than two thirds. How can LHINs accomplish what they are supposed to accomplish when so many important components of health care delivery are beyond their reach?

The RPNAO strongly believes that if the government wants to live up to its commitment of preserving a truly publicly funded health care system that is both transparent and accountable, section 28 should be deleted from the bill.

Our written submission also outlines our concerns respecting not-for-profit providers that rely on charitable donations, as well as the provisions in the bill that establish the health provisions advisory committee for each of the LHINs. For the sake of time, I'm going to leave those concerns for you to read in our submission at your leisure.

Let me close by again saying that the RPNAO lauds Minister Smitherman for tabling Bill 36 in terms of its overall objective of delivering an integrated, community-based health care system. However, we still feel that Bill 36 is deeply flawed. Quite frankly, this wasn't the bill that we had expected or the one we had been led to believe would be brought forward.

Bill 36 creates an even further centralized, ministry-driven health care system. Rather than make decisions on the delivery of health care at the community level, Bill 36 simply creates 14 regional bureaucracies of the Ministry of Health and Long-Term Care.

The RPNAO hopes that this legislation is amended appropriately in order to truly reflect the government's intent of creating a community-based model of health care. If not, we run the risk of slowly evolving towards a

profit-driven health care system, severely affecting the delivery of health care services.

That concludes my remarks, and we will gladly take any questions that you may have.

The Chair: Mr. Gracey, any comments from you? No. Okay. There are about three minutes. I'll start with Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. I'm just trying to get a handle on exactly your concern, because on the one hand you're saying that the bill goes too far, and you're using the word "centralization," which I think the minister anticipated in saying that it's exactly the opposite that we're trying to do. We're exactly trying to put more control over that, more than half of the health care budget, into the hands of local communities and organizations that understand what's going on locally. So that's on the one hand. Then, on the other hand, you're saying that Bill 36 doesn't go far enough because it doesn't include all these other health care providers. The truth is, from our perspective, we're trying to go as far as we can to coordinate locally. Down the line, if there are other groups that need to be included, we will need to look at that. But we've got to start somewhere, and this is what we're proposing.

So can you just explain that conflict in your presentation?

Ms. Young Evans: Bill 36 is going to make a situation even more difficult when it comes to integration and a multidisciplinary team. There are a number of regulated health professions that are not involved. We're finding that, although the accountability is given to the LHINs, the ultimate control is still with the minister—"You're going to be accountable for what you're doing, but I have control." So we do find that somewhat difficult to understand, as well as our responsibility in communicating with the LHINs. It's going to be very difficult, with small associations, to go out and be able to give that consistent message to each of them. I may come to a point where I come to the ministry looking for money for transportation and communication needs, only because having the ministry here being able to do that strategic planning and management with a centralized source is much easier for all of us, and I think it behooves the ministry to ensure that the LHINs are responsible for communicating with us on a regular basis.

The Chair: Madame Witmer, please.

Mrs. Witmer: Thank you very much for an excellent presentation. I guess we have heard that in this bill there is tremendous power shifted to the minister beyond anything in the history of this province.

What type of amendment would you suggest should be made to make sure that he or she would not have ultimate power?

Ms. Young Evans: Well, if the LHINs are to be made accountable, then the LHINs should have the power to make those changes. Section 28 aside, which we think should be just left out—or, as OAHNSS has suggested, given to all providers. The LHINs should also be able to

have the responsibility and the control to make the decisions that they need to make.

Mr. Don Gracey: If you look at all the regulation-making powers that are in Bill 36, basically the government has exactly the same control over LHINs as it does over Ontario's agencies, boards and commissions. So that is not a decentralized system. That is not a community-based decision-making system. What we would suggest is that the government back away from some of those regulation-making powers and other powers. For example, we don't think the chairman and vice-chairman of the board should be appointed by the government, because that's an essential prerogative of any board. Any board that cannot appoint its own chairman, where the chairman is appointed elsewhere, has been significantly neutralized. We think that at least some of the LHIN board members should be appointed locally, rather than by the minister. But, as I say, if you look at that extensive list of regulation-making powers, even to the point where the minister approves the bylaws of the LHINs, as far as we're concerned, that's excessive.

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The Chair: Thank you, Madame Martel.

Ms. Martel: Thank you both for being here. To follow up on that is the second point, which is that while the minister talks about this being at the community level and community involvement, the extent to which the community is actually going to be involved in any kind of decision-making is left to regulations, and there are no principles or priorities or objectives or a framework for that involvement anywhere in the bill. You've already highlighted those numerous sections in the bill where the government, i.e. the minister, has more control than ever before, not the community.

The point I really wanted to focus on was the managed competition. You were here earlier as well. You heard the minister say that those people who talk about managed competition don't know what they're talking about in reference to this bill, because it's not in the legislation. That is the point. There's nothing in the legislation that says how the LHINs are going to acquire, obtain or get their health care services. Competitive bidding wasn't a legislative change; it was a policy change by the ministry that had CCACs do that in that regard.

I wonder if you can just expand on your concerns about competitive bidding, seeing what you've already seen in the home care sector.

Mr. Gracey: Your point is exactly what we were trying to say. There is nothing in the bill that says that Bill 36 is going to introduce managed competition into the health care system, but there's a lot that isn't in the bill. As I said earlier, there's a ton of stuff that's going to be defined by regulation or otherwise. We don't know how those regulation-making powers are going to be used.

What we do know is that CCACs are going to be more integrated with the LHINs. CCACs have been using managed competition for some time. The government has not turned back managed competition. We have asked for

assurances that the LHINs will not use the powers and the objectives given to them by Bill 36 to spread managed competition more widely. We have not been given that assurance.

The Chair: Thank you very much for your presentation.

ONTARIO MEDICAL ASSOCIATION

The Chair: We'll move on to the next, from the Ontario Medical Association. We have Jonathan Guss, chief executive officer, Dr. Greg Flynn and Dr. Steven Harrison.

Dr. Greg Flynn: Thank you very much, Mr. Chairman and committee members. Good morning. I'm Greg Flynn. I'm the president of the Ontario Medical Association. Joining me today on my left, your right, is Mr. Jonathan Guss, our chief executive officer, and Dr. Steven Harrison, our director of OMA health policy. I want to thank you for allowing us the opportunity to voice our concerns about Bill 36. I also want to take the opportunity to thank those in the Ministry of Health and Long-Term Care, as well as the Legislature, for all their work to date on this important file. Following my presentation, I look forward to answering any questions the committee may have.

I've been working with the Ontario Medical Association in some capacity for many years. Now there are four months left in my tenure as president. Over these many years and throughout my presidency, the OMA's message to government has been constant: Doctor shortages and wait lists threaten the health and safety of our patients.

While we have struggled to provide the care we were trained to give, Ontario's doctors have been closely watching the government in their efforts to improve the health care system, first with Bill 8 and, more recently, with the transformation agenda: family health teams, information management, the wait list registry and local health integration networks. This plan is aggressive, and the timelines are short. The articulation of the plan has been less than clear. But while we have not always agreed, we've always been able to work together in the end to find common ground, to develop solutions that are beneficial to our patients. We hope to continue to work closely with you as the system moves forward in Ontario.

Before I speak directly to Bill 36, I'd like to make clear that our patients are the number one priority of Ontario's doctors. As such, we realize the importance of working with government to ensure that our patients are protected and that their care remains paramount in the development of this integrated system. Our patients deserve timely access to quality care, care that often only a physician can give.

I hope you'll agree that doctors play a vital role in the delivery of health care. We are on the front lines and the final lines of health care in Ontario. We take Ontarians from birth to death. We help them and care for them through all stages in between. We see how the system

functions first-hand as we work within it every day, collaborating with physicians and other allied health professionals, institutions and planning bodies to ensure the delivery of health care to all Ontarians.

There's no question that we must be able to bring these experiences to the table in order to find the best solutions to provide better care for Ontario's patients. Patients must remain the main beneficiaries of any change in our health care system. Their well-being should be the top priority when deciding what path to take.

That said, we feel that LHINs may be an opportunity for Ontario's patients, an opportunity to bring a local flavour to care. The term "local" does resonate for me; however, there is little that's local in some of these LHINs, which span possibly hundreds of kilometres from one end to the other. Hospital referral lines or not, some of the LHINs seem unwieldy in their size. Bill 36 and the institution of the LHINs in Ontario will fundamentally change the way health care is delivered in this province. The input of physicians will be paramount to achieve any success in this regard.

Our primary concern with the bill is here: The legislation, as written, does not specify a role for physicians to provide independent input. As such, the Ontario Medical Association asks that Bill 36 be amended to mandate a formal mechanism for physicians to provide meaningful input to the local health integration network decision-making process. Physicians need to be involved in the management and organization of health care where they provide it. We have an important role to play; our insight is unique and therefore vital.

Section 16 of the legislation allows physicians to provide input into a larger committee for health professionals: the health professionals advisory committee. We do not believe that this format will be workable or effective in bringing the real concerns of physicians to the local health integration network decision-makers. Where will physicians who work so closely with patients and with each other bring their concerns for solutions and their advice for improvement? The current format is not sufficient. In all other provinces and throughout the world, the major success factor in the integration of health care has come through the involvement of physicians in the process.

In Alberta, they attempted integration and regionalization without directly involving physicians for many years. They realized that the process was not just slowed; it was halted. After years of non-involvement and years of repairing a damaged relationship, Alberta now involves physicians one-on-one in their regional model, locally. The recent apparent success of the Alberta model in its endeavours of integration and regionalization can be linked to the involvement of front-line physicians in the decision-making process.

In British Columbia, their health care system endured significant turmoil and instability for almost a decade before the government directly engaged the physician community and relative calm was restored.

So I tell you now that direct physician consultation is essential in order to avoid the experiences in Alberta and British Columbia.

I encourage you to look to these examples. Do not make the same mistakes. This is a well-travelled path and one for which we now know the right direction. Learn from the mistakes of others. There is value in reflecting upon history and not charging blindly into the future. There is a way that the local health integration networks will work, and work well. We ask that you allow us to help you along that path.

The Ontario Medical Association has been working to develop a model of local representation for physicians that will be applicable in Ontario's new integrated system. We'd be happy to share this model and its organization with you for your consideration.

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I want to keep this presentation short, so in conclusion, I'd like to make clear our goal to assist in the successful integration of health care services in Ontario. We want to create a better system, one that is better for our patients and one that is better for physicians. Why wouldn't we? But we must ensure that local health integration network decision-makers learn from our experiences on the front lines in hospitals, long-term-care facilities, mental health facilities and primary care facilities across the province—the voices of Ontario physicians. Our advice and concerns must be heard where and when it is most important, where decisions are made that will affect how our patients receive their care. Our input is key to ensuring that patient care and access to care are not adversely affected.

We do look forward to working together to help ensure that Ontario's patients receive the best. They deserve it. I'm now pleased to take any questions that you might have.

The Chair: Thank you, Dr. Flynn. There are about four minutes and half, one and a half each. Madame Witmer, please.

Mrs. Witmer: Thank you very much, Dr. Flynn, for your presentation. I think you, like most other organizations, have indicated your support for the principle of LHINs and the integration and regionalization. But you've pointed out, I think I hear you say, the size of the LHINs, the huge geographic area, and the fact that the model currently doesn't provide physicians with an opportunity for meaningful input. Obviously, we've seen the consequences of that not happening in Alberta and BC, where I would agree there was some turmoil.

What would you recommend? What type of change should be made to this bill in order to ensure that physicians do have meaningful input?

Dr. Flynn: First, I want to say that the Ontario Medical Association supports the concept of a health professional advisory committee and would like to work in that environment, but I do recommend, because of the close relationship that I often refer to as the six degrees of separation between specialist physicians who have taken care of the same patient, there are complex

interrelationships that are necessary to recognize in order to provide integrated care. We believe that the full physician community, which includes primary care, community-based specialists, diagnostic facilities, long-term-care facilities, and the hospital-based physicians need a forum to provide medical advice.

Mrs. Witmer: Would that be a separate forum outside of the advisory committees?

Dr. Flynn: Yes.

Mrs. Witmer: Okay.

The Chair: Madame Martel.

Ms. Martel: Thank you for being here. Let me just follow on that model because I'm not aware of the Alberta model with respect to physicians. Is it a separate and stand-alone committee in each regional health authority, then, that provides input?

Dr. Flynn: Yes, it's—I don't want to prejudice your thinking about it by calling it a medical advisory committee, but they have a regional medical body.

Ms. Martel: That has an association with each regional health authority.

Dr. Flynn: That provides advice to the regional health authority.

Ms. Martel: And do physicians—are there other advisory committees of health professionals that physicians also sit on in Alberta?

Dr. Flynn: I can't speak for whether they sit on them, but there are other professional bodies that provide advice.

Ms. Martel: Okay. Thank you.

The Chair: Madame Wynne.

Ms. Wynne: Thank you very much for coming here today. I certainly take your point about the importance of the role of physicians. Subsection 16(2), you rightly identified, is where the health professionals advisory committee is outlined. You're suggesting that you do support that committee but that you'd want a separate committee. Is that what you're saying? You'd like a separate committee in addition?

Dr. Flynn: Yes.

Ms. Wynne: Okay. And I guess my question is, are you suggesting then that all other health professionals should have separate committees as well? That's where we get into a difficulty.

Dr. Flynn: I can't speak to that. What I can speak to is the need. As a patient makes their journey through the health care system, starting with the community services, moving through some institutionally based services, the relationships between the physicians of different specialties can't be accounted for in a multi-disciplinary body. I would tell you that because the doctors are unlikely to be as forthcoming about problems they are having in solving integration issues in a broad-based community like that.

Ms. Wynne: Well, maybe that's the issue we need to get at: how to get that dialogue going with all the health professions at the table. Thank you very much.

The Chair: Thank you, gentlemen, for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES ONTARIO

The Chair: We will move to the next one. It is from the Canadian Union of Public Employees of Ontario. Mr. Sid Ryan.

There has to be a change.

Mr. Michael Hurley: Yes.

The Chair: Just have a seat and I'm sure you will give us your name, sir.

Mr. Hurley: Michael Hurley. I'm the first vice-president of CUPE Ontario. With me is Doug Allan. He's a senior research officer with CUPE. I apologize; Mr. Ryan is in Cuba, actually, recovering from the federal election.

CUPE has 220,000 members in Ontario, of which 82,000 are hospital, retirement home, long-term-care, home care workers or workers in the affected social services. So we have a keen interest in this legislation.

I'd like to address up front the problems that we have with the government in terms of its vague assurances around the privatization issue. This is a government that campaigned against private-public partnership hospitals and has subsequently announced 23. So we're very skeptical when there are broad statements about opposing privatization made by the government, and we're looking for concrete measures in the legislation.

I'd like to say that there has been no consultation with the workforce in the health care sector around the LHIN legislation, which is stunning when you think about it. Even though we're all involved in delivering these services, there has been no consultation with us about that. And this is a workforce that has been subjected to ongoing restructuring, including, in the hospital sector, the hospital restructuring commission and massive change and disruption in the home care sector.

I would argue that there also has been no meaningful consultation with the public. Hundreds of people have asked for standing before this committee and have been turned down, and I'd ask that this committee look at scheduling additional days of hearings. The public meetings that were held to discuss the LHINs provided almost no real information and offered almost no opportunity for real dialogue. But the LHINs themselves are not democratic structures—they're not elected; they're not accountable to their communities—so it's no surprise that the process that purported to give them birth in terms of consultation was not a democratic one.

The government is concerned about health care spending, and rightly so, but the major cost drivers that are pushing up health care spending are the doctors and drug costs, and neither of these are covered by the LHINs. Let's just stop there for a second: The doctors are not covered by the LHINs. How do we have an integrated health care system which does not involve the doctors? Frankly, the doctors are not part of the LHINs, we believe, because they're too powerful to be included. Our members' wage increases of 2.5% and 3% in the last two

years are not the factors that are driving health care spending out of control in the province of Ontario.

The Minister of Health purported that the LHINs are moving control closer to the local level. We would challenge that assumption. We would argue that the LHINs are actually a massive power grab by the Ministry of Health and the provincial government over local institutions in their communities. This is a centralization of power masquerading as a regionalization. The scope of the restructuring is massive, and the consequences for local community organizations of a not-for-profit nature in hospitals and other settings are going to be huge. In fact, the governance structures that are in place, for example, in the hospital sector are not going to have a lot of meaningful control any longer about services.

LHINs are not local by any means at all. The geography of the LHINs is just incomprehensible. Metro Toronto, for example, is split into five LHINs. Each of Metro's homes for the aged is in a different LHIN. How can that be? The only rational explanation for that is to divide up the power of the people of Toronto to have, really, any meaningful say in the restructuring which is coming.

In terms of accountability, the fact that the LHIN boards are appointed by order in council and are not elected by their communities is a huge concern, especially in concert with basically taking all the powers away from local community boards. The LHINs will add another layer of bureaucracy to the health care system. We're not going to see more registered nurses, more registered practical nurses; we're going to see more lawyers, more accountants and people who specialize in putting stuff out to tender.

The LHINs are going to introduce the competitive bidding model. The minister says they won't. Then we ask: Make it explicit in the legislation that the LHINs cannot use competitive bidding or managed competition; they cannot tender for services. Make that explicit.

1020

In terms of what the minister has told us so far, he has told us that the government is going to set a price for services in hospitals, starting with the five areas that are targeted by the federal government for wait time reductions, and those are: cancer care, hips and knees, cataracts, MRIs and CAT scans. But his intention is to quantify every hospital service and to have the LHINs purchase that. That has two huge consequences, one of which will be the consolidation of these services into large urban centres and outside of smaller communities. That is going to effectively mean the closure of many hospitals. They may still have urgent care centres or emergency wards operating, but the days when you could give birth in Lindsay or Campbellford or Kenora are coming to an end under the LHIN regime.

The other consequence is the impact that competitive bidding is going to have in terms of care and on the labour market. In terms of care, you don't have to look any further than what happened when the previous government introduced managed competition as its policy in terms of how to deal with home care.

Dr. Jane Aronson at McMaster University has done studies which we'll include in our formal brief with our amendments, which we'll be tabling with you by February 8. She studied what happened to the people who received care in the home care revolution that occurred, as organizations like the Victorian Order of Nurses were plunged into bankruptcy because they could not compete with the multinationals that moved into the sector, which are now dominant in the sector; what happened, with turnover rates of home care workers which are now at 57% every year, in terms of care for clients who withered and suffered as a result of that. You need to process what managed competition really means in terms of care.

What it has meant in terms of the labour market has been a 10-year wage freeze at best, but oftentimes people are losing their jobs every two years as contracts turn over. They have no job security, they have no regular hours of work, they have no pensions, and they have no benefits. This is not a labour market model that we will accept in terms of expanding beyond home care at all. In fact, it has to be reversed in the home care sector.

The section 33 powers which the ministry has given itself to detach hospital support services and move them to other providers are a huge concern to us. You need to look at what's happened in other jurisdictions like British Columbia and the United Kingdom where there has been this enthusiasm for the privatization of support services, where those services are moved to multinationals and 15% or 20% of the money that's currently spent on something like hospital cleaning instead gets transferred to shareholders in Paris. What it means practically is skyrocketing incidences of hospital-acquired infections; what it means is people skimping on cleaning supplies, on gloves and on cleaning products so that they can deliver a more efficient service.

If this is the area that the minister believes there are huge savings to be made in and he's intending to accomplish it by detaching these services and privatizing them, then there's going to be a huge fight about that. It's one thing to argue, for example, that there should be one payroll system for Ontario health care facilities. That's fine, provided we're talking about what happens to the workers who are currently doing that work who are now going to be surplus. But if the proposal is to create one payroll service and to have it administered by IBM, Telus, Accenture or Sodexo or Compass—if that's the intent of the legislation, then there's going to be a huge battle about that with your workforce because we're already stressed to deliver these services with our current numbers. I can't imagine what's going to happen with the business plans that are in place for things like hospital business systems, which contemplate a 40% reduction in the workforce.

I'd like to talk about the impact on collective bargaining. The LHINs have the potential to destroy the provincial labour market systems which have been put into place—that is to say, provincial bargaining—and that is an unacceptable outcome.

Finally, I'd like to say that the amendments to Bill 136 that the government is contemplating are going to have the effect of squandering a lot of money—that should be spent on patient care—on legal issues and at the Ontario Labour Relations Board as we have representation votes every time a small group of workers or a program transfers from one institution to another.

I'd like to conclude by saying that there were a lot of statements this morning from the minister in terms of this legislation not introducing competitive bidding. I'd like to reiterate the challenge to you: If that is in fact your intent, then you make it explicit in the legislation that there will not be a managed competition model put in place for health care services in Ontario and that you're going to withdraw it from the home care sector. Thank you.

The Chair: We'll have about a minute and a half each. Before I recognize Madame Martel, just for the record, two thirds of the people who did ask to speak to us will be making a deputation. Originally the committee agreed on four days, plus more if necessary, and we extended it to seven days. We are going to have four days in Toronto, one day in London, one in Ottawa and one in Thunder Bay. So we have done that to accommodate as many people as possible.

Having said that, your comments are well received. I will ask Madame Martel to make her own comments.

Ms. Martel: Thanks to both of you for being here this morning. I appreciate the comments you made, specifically about managed competition, because you were here for the minister's comments when he said that it's not in the bill. No, it isn't; that's the exact problem, because there's nothing in the bill that says how they're going to acquire these services, and there was nothing in any legislation that allowed the Conservatives to do the same.

It's interesting that the government has not gotten rid of managed competition or cutthroat bidding in home care. The government hasn't even responded to Caplan's report, even though they promised to do that last fall. I remain very worried that cutthroat bidding is coming to health care services near to you, not just home care but a wide variety. I wonder if you can just explain to the committee again what that has meant for so many of your members and why you're concerned that that be expanded to other health care services?

Mr. Hurley: Competitive bidding is hostile to the concept of integration, which is key to this bill. Jane Aronson from McMaster says that the competitive bidding model destroys the collegiality between health care providers. That's what it did in the home care sector, because people have to compete with one another to achieve the contract that's tendered by the CCAC. As a result, people are reluctant to share information etc. in terms of new procedures or whatever might enhance care.

In terms of the workforce, though, the impact has been devastating. You have people who've worked for an agency who lose the contract, who can never achieve more than 20 hours of work a week, because if they did,

they'd have to receive benefits. They don't have any hope of having a pension. They've often negotiated wage cuts of an ongoing nature so that their employers can compete for services. They can't afford to subsidize the system, so you have a turnover rate of almost 60%. This is the labour market.

And who are these people? These are women; in the home care sector, these are primarily new Canadians, people of colour. This is a hostile labour market policy, from our perspective. The thought that you would extend it across the hospital and long-term-care sector is just totally unacceptable to us.

The Chair: Mr. Fonseca, please.

Mr. Peter Fonseca (Mississauga East): I'd like to thank you, Mr. Hurley, and CUPE for your presentation. In regard to some of your comments in terms of the minister's meetings with different stakeholders, the minister did meet with CUPE in the minister's office—that took place in October 2004—along with a number of workshops that have happened. He's actually consulted with well over 4,000 stakeholders. I was at a number of those workshops. There were his breakout meetings. It was all into bettering and making our local health integration network the best it can be.

We've also learned much from other jurisdictions, and from those other jurisdictions where they did have elected boards at one time, they did not work. They did not work throughout Canada, and they've reverted back to appointed boards, partially through the ministry and through the community. That is what has worked in other jurisdictions. So the minister has really looked, where we've had the opportunity, to see what has worked or what hasn't worked in other jurisdictions and to bring the best here to Ontario. That's what the minister is doing.

I know you mentioned the closure of hospitals. The minister, if you heard his remarks here, has said that under his watch, under this government's watch, no hospital would be closed in Ontario. His remarks were made here this morning. In your opinion, should we not learn from what has happened across Canada and bring the best to Ontario so that, as the minister said, we could put the patient squarely at the centre of health care here in Ontario? This is about the patient.

Mr. Hurley: What the minister has told us is that hospital procedures will be quantified, that a price will be set for them. There will be a tender, and the tender will be awarded to those who can deliver the services, who has the HR capacity to deliver the enhanced volumes. Over time, you're going to see the movement of many hospital procedures out of smaller communities and into large urban centres.

Is it a reasonable expectation for a woman in Kenora or Smiths Falls that she can give birth in her community? It will not be a reasonable expectation in the future. You have to ask yourself how it can be that one of the richest provinces in one of the richest countries in the world cannot contemplate a health care system where a woman has the right to give birth in her own community. We have the resources for that.

This is not a factory that we're setting up here. As you know very well, these are services that are vitally important to people. They need to be close to home; they're not going to be.

1030

Mr. Arnott: I appreciate your presentation this morning. I expect that we'll hear from Canadian Union of Public Employees representatives as we travel the province in the next few days, and perhaps even when we come back to Toronto next week.

I don't know if you were here for the minister's presentation this morning, but after he concluded it, he gave the clerk of the committee a copy of his notes. It was interesting to read some of the things that were scratched out. For example, on page 6 of the original draft, which perhaps his staff had prepared for him, it said, "We set out to craft a piece of legislation that would ensure that decisions would be taken in a transparent, accountable manner, based on priorities set in communities, after open public meetings and extensive consultation." However, the minister scratched out the words "and extensive consultation." I gather he assumed he was going to be criticized for the minimal, inadequate level of consultation with groups such as CUPE and didn't have the audacity to say that to the committee, but it was in the original draft. Would you care to comment on that?

Mr. Hurley: We met with the minister's staff, I think, the morning that Bill 36 was introduced. That does not constitute consultation, in our view. One thing that really disturbed us during the SARS crisis was the extent to which the Ministry of Health operated by issuing edicts to its workforces and not consulting with us, even though we have the specialization around infection control, hospital cleaning etc. which could have reduced the impact of that disease. Half the SARS cases were hospital workers, so this consultation thing is a huge issue for us, and there wasn't any.

I don't believe that there was any real consultation with the people of Ontario either. So you still have hundreds of people who want to appear before this committee to have some input, and they're being turned away. That is not right.

The Chair: Thank you very much for your presentation.

ONTARIO NURSES' ASSOCIATION

The Chair: We'll move on to the next presentation, the Ontario Nurses' Association, please. You can start any time you're ready.

Ms. Linda Haslam-Stroud: Good morning. My name is Linda Haslam-Stroud. I am the president of the Ontario Nurses' Association. With me today are Lawrence Walter, our provincial government relations officer, and Jan Davidson, who is one of our managers and has dealt with the restructuring across health care over the last 30 years in the Ontario Nurses' Association.

I am a registered nurse and have worked for over 28 years in the hospital sector, so I've lived through more than my share of restructuring.

I wanted to comment to you that ONA is not resistant to change. We welcome integration, as the minister quoted from our 15-year-old document this morning. However, he also said that the consequences of not getting it right are very important. So I'm here today to tell you that the consequence of the present legislation as it's tabled is not getting it right.

We are not wedded to the status quo, but we support changes that we believe are going to assist us in providing quality care to our patients and support the registered nurses of Ontario who, we are told, are the heart of health care.

ONA represents 51,000 registered nurses and allied health professionals across Ontario. In the Toronto area alone there are over 18,000 registered nurses; that's region 3 in our structure. That actually covers all or part of five LHINs. We have members working in all sectors included under Bill 36: hospitals, community care access centres, community health centres and long-term-care facilities.

We also have members who provide public health services, which, as you know, are excluded from Bill 36.

As you can imagine, health care reform is of vital interest to our registered nurses in Ontario. It is our belief, however, that Bill 36 as currently drafted neither safeguards the professional interests of our members nor protects access to and the delivery of quality, comprehensive care for our patients.

Today, although we have many concerns with the bill, I am going to focus on a number of ONA's priorities in key areas. They include providing for a health human resource plan for quality care delivery and to protect the rights of health care professionals, including registered nurses; providing for consultation on, and input into, the development of the provincial strategic health plan; and ensuring that key health care providers are included under LHINs to facilitate meaningful integration.

Our vision to get it right—as Minister Smitherman says, "Pass the very best legislation"—starts with the premise that effective integration coordinates access to quality and comprehensive services in order to implement a seamless continuum of health care for our patients.

In short, we disagree with the government's conceptualization of integration set out in Bill 36. Concepts missing from Bill 36, but in our view fundamental to genuine integration of health care, are patient-centred care, including a focus on outcomes and access to high-quality, comprehensive care within a publicly delivered model; inclusion of all major providers of health care services; open and transparent integration decisions based on the public interest and based on public priorities; and health human resource planning.

Integration in Bill 36, however, is defined in section 2 in the blunt language of restructuring. Health care services can be transferred, merged and amalgamated. Services or operations can cease, dissolve or wind up. The reality is that hospitals could end up closing, because if there is a competitive model and if all the services are

being moved away from hospitals under the LHIN boards' decisions, hospitals are not going to be able to continue to function.

The registered nurses' vision in Ontario is much different. We believe this reform of health care should be all about better coordination to improve the patient care that we provide, not about rationing care or reducing services to achieve economic efficiencies. We are already seeing the loss of RN jobs in Ontario. We are already seeing the transfer of services out of hospitals to for-profit operations. Our vision is for an integrated system that coordinates services to implement seamless health care for patients in a manner consistent with the principles in the preamble to the Commitment to the Future of Medicare Act, which the minister referred to this morning.

Let me now turn to a review of three overriding concerns we have identified in Bill 36. If we agree that the purpose of the bill should be to implement seamless health care, then the exclusion of health care services from LHINs makes absolutely no sense to us. We believe that exclusion is a mistake. How can there be meaningful integration, we ask, without consideration of all health services? Of particular concern to nurses is the current exclusion of public health, independent health facilities and physician and primary care.

Public health services, in our experience, are an integral part of the integrated health care system. SARS—we've all lived through that—demonstrated the dangers of the currently fragmented and underfunded public health system, and their exclusion from LHINs will add more uncertainty during emergencies.

From the perspective of nurses, physicians seem to have been given a special deal once again, because they are excluded from Bill 36 and will continue to negotiate directly with the provincial government. Let there be no mistake: LHINs will not be the gatekeepers of this health care system. The physicians are the gatekeepers of the health care system, and they are excluded from this legislation. We are asking you and the government to take a hard look at that, because at the end of the day we need full integration so that all health care providers are included. We certainly believe that physicians and primary care should be part of the provincial strategic health care plan as well as be included in the integrated health service plans developed by each LHIN.

In addition, we do not believe that primary health care services should be treated differently—included in Bill 36 only if they are provided by a community health centre. We are extremely concerned that the coordination of transitions between primary, community and acute care will be inadequate, because primary care physicians will have little incentive to become a part of integration decisions. We have similar reservations regarding the coordination of, and input from, public health services.

We also believe that independent health facilities should not be excluded from Bill 36. We are concerned that this will mean that hospital services that are currently publicly delivered will be moved into privatized com-

munity clinics. Although we're saying that we're not going to have the patient pay anything, the reality is that there are many services we provide in the hospitals each and every day that are not covered under the Canada Health Act. As you move those services out of the hospitals and into the community, by virtue of the act, those patients are now going to have to start paying for those services. Physio might be an example of that.

1040

Already we have seen companies getting ready to operate private primary care clinics in Ontario as early as this summer. Let's look at what the best research shows. In the United Kingdom the results are in: There are fewer RNs caring for patients in Britain. For your information, if you are not familiar with the literature, Canadian literature shows that there is increased morbidity—in nursing lingo, "increased morbidity" means increased disease—and increased mortality, which means death. There is increased morbidity and increased mortality as you reduce the number of registered nurses caring for patients. This is a very major concern to us, obviously, for the quality of care that we believe our patients deserve.

As currently drafted, Bill 36 puts in place a framework for the consolidation of services and disruption in delivery systems that, if undertaken, we believe will undermine patient accessibility and quality care. Actively encouraging the transfer of services out of hospitals into independent health facilities is one such example where the bill fails to preserve medicare and prevent user fees. That was the example I just gave you.

Let's move now to the lack of provisions for effective input from employees and their representatives. First and most importantly, we are concerned about the lack of an open process to determine the provincial strategic health care plan. Let me give you a few details. The fact that there is currently no requirement or process for broad public consultation regarding the provincial strategic plan for the provincial health care system that the minister is charged with developing under section 14 in our opinion is one of the most glaring oversights of the bill. We believe this is a glaring oversight because it is this plan that will form the basis for local integrated health services plans being developed by each LHIN. We understand that the actual provincial strategic plan isn't even going to be out before the LHINs plans are available. We are therefore calling for a green paper on the provincial strategic health plan to be released well in advance, and to form the basis for broad public consultation.

I would now like to turn our attention to a topic that I feel very strongly about. I am absolutely mystified how the minister would introduce legislation that is essentially silent on the issue of health human resource planning. If there's one topic that nurses have been pressing, it is the crisis we face because there are not enough nurses to provide the care our patients deserve. Because of the training time required to educate new professionals, health human resource planning needs to be done many years in advance to ensure that the specific needs of each

community are met. Because Bill 36 jumps directly into restructuring without addressing the issues that impact on recruitment and retention, such as the need for ensuring the continuity of representational and individual rights, we believe it will create a health human resource disaster. No consideration appears to have been given to how restructuring will splinter employment between sectors, how it will undermine wages, pensions, benefits and job security. Maybe it does answer that question, because it is going to gut it. An example given by the minister this morning was about satellite dialysis clinics. I can tell you that those for-profit clinics have nurses working in them who do not have pensions, have lesser wages, have no job security, and they're moving in and out, through the system, trying to provide quality care to the dialysis patients. I'm a renal transplant nurse, so that is very much part of my heart in looking at the nephrology patients in Ontario.

In addition, no thought seems to have been directed to the impact of the integration decisions on current bargaining structures. You heard Michael Hurley speak of that as well. Central bargaining for nurses in Ontario in the hospital sector covers 45,000 nurses, and we predict that, since there has been no direction given regarding bargaining structures, this could actually lead to labour relations chaos. We will propose in our written submission, which we will be providing to you by the deadline, that Bill 36 be put on hold until a thorough consultation has been conducted on the impact of this legislation on health human resource planning issues.

Even if some health services are not defined as health service providers and therefore are not funded by LHINs, it is our view that PSLRTA, the Public Sector Labour Relations Transition Act, should apply to any transfers or integrations caused by restructuring that impacts on the employment of health care workers. Therefore, we will propose that PSLRTA apply to all health care restructuring, whether or not the successor employer is in health care. I'd like to hear you guys say that quickly. You're laughing at me. It's hard. In our view, this proposal is the only way to ensure that there is at least some attention paid to the rights of health care workers and registered nurses during this restructuring.

Further, we will propose the removal of restrictions on the application of PSLRTA. Without these amendments, we predict there will be extensive litigation at the labour board. We'll see litigation over whether PSLRTA should apply, inequitable treatment of the rights of health care workers, and extensive litigation under the successor rights of the Labour Relations Act. As you know, they're already under-resourced.

PSLRTA should apply to all health care restructuring unless the employer and the unions agree it does not. We will put specific provisions in our amendments, making the legislation retroactive as well, to cover the gutting and the restructuring we've already seen.

Health human resource adjustment plans should be promoted in the legislation. It should provide for a smooth transition of the affected employees and address

the issues of the transfer of job security, portability of benefits, retention of terms and conditions of employment, and representation rights.

As you can tell, we do not believe that Bill 36, as currently written, provides a firm foundation to build an integrated health care system, and it does not include the key elements: Critical health services are excluded; it does not mandate public consultation for the provincial strategic plan; it does not focus on access to comprehensive care; it does not plan for health human resources.

Our amendments, we believe, will address Minister Smitherman's concerns regarding patients being the centre of care. Every dollar of our money as taxpayers should be provided to patient care. If competitive bidding is not in LHINs or foreseen, then put it in the legislation. Our patients do come first and our amendments, we believe, are needed to provide quality patient care to the patients of Ontario.

The Chair: Thank you very much for your presentation.

SERVICE EMPLOYEES

INTERNATIONAL UNION, LOCAL 1.0N

The Chair: We'll move on to the next presentation now. It will be from Service Employees International Union, local 1.0n. I believe Cathy Carroll will be speaking on this. Ms. Carroll, please have a seat. You can start anytime you're ready. There are 15 minutes in total. Please proceed.

Ms. Cathy Carroll: Good morning. I'm Cathy Carroll and I'm secretary-treasurer of the Service Employees International Union, local 1. SEIU, local 1, represents 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services in Ontario.

The Local Health System Integration Act, Bill 36, in its present form, will radically alter the kind of health care service Ontarians receive, how these services will be delivered, who will profit from the services delivered, and who will lose as a result of the integration, amalgamation and devolution of health care services.

Contrary to the Orwellian language of Bill 136, or Bill 36—and we could get those mixed up quite easily—the legislation will remove any local control over health care and place the control of health services solely within the power of the Minister of Health and Long-Term Care and the Ontario cabinet.

The Minister of Health and Long-Term Care professes his commitment to the Canada Health Act, but this legislation is an attempt to further circumvent the principles of that act. At the very least, the preamble and section 1 of the bill must contain specific commitments to ensuring that the principles of the Canada Health Act are maintained.

As this bill now reads, every health care service not covered by the Canada Health Act will be subject to privatization. The government is moving this legislation forward without a strategic plan for the delivery of health

care in Ontario. A provincial strategic plan is needed to be put into place before the LHINs can even start to develop their plans.

SEIU asks that members of this committee delay third reading until the government has held broad consultations with all of its stakeholders. The strategic plan must also include a human resource plan. To have any legislation that's going to have broad, sweeping effects on a workforce without having a human resource plan in place prior to the legislation being adopted seems kind of like putting the cart before the horse.

The legislation is flawed and its premise is based on cost containment of health care and not on ensuring that Ontarians have equal access to quality public health care services. The real name of the legislation should be the Ontario balanced budget act for the 2007 election.

1050

Health care workers are now subsidizing their own wages, up to \$900 per year, in a health care tax. Every hour a nurse works, 50 cents goes to the Liberal health tax. Apparently, the government believes that health care workers can sacrifice even more with the introduction of this bill.

LHINs are undemocratic. The boards are not elected. Sections 7 and 8 of Bill 36 must be amended to provide for the election of LHIN boards of directors. That the legislation gives greater control over health services to local authorities is just patently false. What chance would a small community have to decide what health services it wants when the community is lumped into a LHIN with larger metropolitan centres? Section 9 suggests that LHIN meetings are public, but what citizen would travel 200 kilometres or more to attend a board meeting?

Reconsideration of LHIN decisions, as outlined in sections 26 and 27, do not allow affected parties much time to appeal: 30 days. Will unions holding bargaining rights have the right to the reconsideration process? That's not clearly outlined. The very short time frame for any party to make a submission for reconsideration and to study the impact a LHIN board decision will have on a local health service suggests that the government wants to limit the appeal process.

Why does the government draw the line at the health care providers, as defined in the act? Why are independent health facilities, physicians, laboratories and ambulance not included? These independent health facilities could be operated as private clinics but funded by public health care dollars. Physicians are excluded from the legislation. We ask, how can doctors act in an advisory role without being part of the entire health system?

The legislation gives near-dictatorial powers to the Ontario Minister of Health and Long-Term Care. The Minister of Health will have greater control over the kind, type and amount of health care that's provided in each LHIN throughout Ontario. Section 28 of the bill allows the Minister of Health to order a health service provider that carries out an operation on a not-for-profit basis to cease operating, dissolve or wind up its operation, amalgamate with one or more health service

providers, transfer all or substantially all of its operation to one or more persons or entities, and to take any other action necessary to transfer property. What the LHIN lacks in power, the Minister of Health can do.

Section 33 will allow the government to order health service providers to cease operating and transfer their property. This leaves the door wide open to greater privatization of the health care system. For example, a LHIN could require the transfer of health care services, such as chronic care, from a public hospital to a private, for-profit nursing home.

LHINs financing: The Ontario government promised it would deliver a balanced provincial budget before the election of October, 2007. This legislation will make that promise a reality—the only promise, apparently, that the government intends to keep. The only way this government can balance the budget is to take a big bite out of health care. No LHIN will be allowed to have an operating deficit. This legislation is not about building a better health care system, but rather how to control health care spending.

Even before the LHINs are operational, it is costing Ontario taxpayers millions of dollars in start-up costs. Democratically accountable district health councils were shut down, the hiring of 550 new bureaucrats to operate the LHINs will cost \$52 million, and almost \$200 million will be spent on setting up the bureaucracy. This will not add a single family doctor, medical specialist or direct, hands-on care provider to the health care system in Ontario. Add to this the fact that the government has funded the Hospital Business Services corporation in greater Toronto \$42 million to eliminate full-time jobs at 16 greater Toronto area hospitals, and the HBS will devolve non-clinical services to for-profit providers. We're already seeing this. It is the exact prototype the government wants the LHINs to follow.

When we reviewed the Hospital Business Services model last year, we found no savings or any return on investment that could be achieved. If there is no community control over hospital services, why should citizens bother to volunteer, to raise funds or donate to specific hospital campaigns? If a LHIN has the power to move the service the community raised funds for, why bother with the effort?

Last summer, SEIU met with several Liberal MPPs to relay our concerns about the lack of nursing home standards, the quality and continuity of care in the home care sector, the private financing and construction of Ontario hospitals and also our concerns about the local health integration networks. Many Liberal MPPs told us that it was not the intention of this government to achieve health care savings on the backs of health care workers. Were we again mistaken? Clearly, the legislation will affect every health care worker's livelihood.

Home care workers continue to be subjected to competitive bidding. Bill 36 has the ability to extend the competitive bidding model to all health care service sectors. Everything is for sale, including our workers' livelihoods, and it is not what this legislation is supposed

to be about. Transferring public health care assets to private for-profit enterprises is not what the health system in Ontario was built on.

SEIU represents mainly service, clerical and home care workers in Ontario's health care sector. That's why we're very concerned about Bill 36's terminology: "non-clinical services." Any time there is a transfer of a service, a person or entity under an integration order, the transfer of all or substantially all of the operations of a health service provider and the amalgamation of two or more persons or entities under integration decision, the Public Sector Labour Relations Transition Act, 1997 will apply. However, if the successor employer is not a health service provider and the primary function of that entity is not the provision of services within or to the health care sector, then it will not apply. Non-clinical service transfers will be subject to the provisions of successor employer and sale-of-business provisions under the Ontario Labour Relations Act. PSLRTA will not apply where the Ontario Labour Relations Board issues an order declaring that it does not apply. In other words, the government wants to remove the protection of current collective agreements from health care workers.

Our members' jobs have been under pressure for years. Hospital service and clerical workers' wages average \$33,000 to \$35,000 annually. Nursing home workers average a few thousand dollars less. Most home care workers' annual incomes are below the poverty line.

Many health care workers are immigrants and women. Does the Ontario government really want to create a class of health care workers toiling for poverty level wages, with no benefits and no pensions?

Competition in the home care sector has eroded the continuity and quality of care. Competition in the rest of the health care system will do the same. You've already heard from the previous speakers on the competition and how it has devastated workers' wages and livelihoods.

Nothing in this legislation must override collective agreements or trade union representation rights. Health care workers must be assured that their jobs are protected, their wages and benefits are protected, and their pensions are protected. No integration decision should be made by the government to alter the terms and conditions of employment of an employee, including collective agreements, without their union's consent. The application of PSLTRA should not be subject to the discretion of the Ontario Labour Relations Board.

The integration of the 42 CCACs into 14 will have serious consequences, for both home care clients and service providers. The RFP process has subjected home care workers to second-class-citizen status in the province. They are not entitled to successor rights under the Ontario Labour Relations Act. If the 42 CCACs are integrated into 14 LHINs, they will be aligned to face this new reality. Contrary to Elinor Caplan's observation when she was doing the review on home care that competition is good in the home care sector, all the evidence leads to the contrary. The fundamental element of a home care delivery process must be continuity and quality of

patient care. At the very least, a human resource plan based on this model must ensure that workers have successor rights within the industry.

The successful care agency in the RFP must be bound by any existing collective agreement with the union that represented the employees with the previous agency.

In conclusion, Bill 36 is a revolution in health care, and there will be a lot of carnage left on the battlefield if this legislation passes in its current form.

Bill 36 says nothing about the quality of care that the LHINs will deliver. The bill is about the bottom line, how to balance a budget, Ontario health care workers and consumers be damned.

The Chair: Thank you very much for your presentation, Ms. Carroll.

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ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: We'll move to the next presentation, the Ontario Public Service Employees Union, Leah Casselman, please. Any time you're ready, Ms. Casselman, you may start.

Ms. Leah Casselman: Good morning. How is everybody today?

The Chair: We're doing very well right now.

Ms. Casselman: Good. I'm glad. With me is Patty Rout, who will be presenting right after myself. So we will go through our presentations and then we'll open it up for questions, if that's acceptable to the committee.

The Chair: Terrific.

Ms. Casselman: As you know, I'm Leah Casselman. I'm president of the Ontario Public Service Employees Union. We represent just about 40,000 health care workers right across the spectrum of health care delivery. We are pleased to be here to have the opportunity to formally present our views before this committee. A more detailed written submission will be filed next week.

Sadly, it appears the LHINs are a fait accompli. It appears the minister first decided to set up the LHINs and is now making a plan for the system. It seems to me that you should first plan and not put the cart before the horse.

My union believes it is not necessary to create chaos across the health care system. We do not have to fix what is not broken. We need less fragmentation and more coordination. We do not believe that the proposed LHIN structure will accomplish that.

We first heard about the local health integration networks in July 2004, when many of our members and staff were on holidays, surprisingly enough. We heard almost by chance that the ministry had concocted a plan to restructure health care in Ontario. We were shocked and offended that plans of this nature were being rolled out in the midst of a summer vacation season while virtually no one was paying attention and without any public consultation. Our union raised the alarm then and has continued to be active in informing the public about

the LHINs. We also understand that Monique Smith was brushing her teeth at the time she heard our radio ads and dropped her toothbrush in the sink, because of course they thought no one knew what was going on and they could just kind of slide it through.

As time passed, we learned more about what this government had planned for health care workers. We learned that the government was planning to set up 14 unelected, unaccountable entities to control health care. We learned that these new bureaucracies would be able to open the door to competitive bidding right across the health care system. We learned that they would have the power to move services around within their regions, depending on who could provide the service of course at lowest cost. And we learned that jobs and patient care were at risk.

In November 2005, a coalition was formed by the four largest health care unions to step up the fight against these LHINs. We've held meetings this month in 17 cities for members of the four unions. We have listened to the concerns of our members—and there have been lots.

Interruption.

Ms. Casselman: There's not a message on there for me, is there, Peter?

The Chair: Please proceed.

Ms. Casselman: We will be hearing some of our members directly over the next few days, and I hope that you would pay more attention to their presentations, perhaps.

Also this month, 160 of our members of OPSEU in regional offices in the Ministry of Health were among the 300 workers who became the first casualties of LHINs. These workers have an excellent knowledge of the health care system in their regions, but they, along with their expertise, have been shoved aside to make room for political appointees. I understand there is one at the back of the room here.

Our members see this bill as opening the door to competitive bidding, while moving accountability and transparency out of our health care system. Our experience tells us that this is a mistake. Let's go back to the summer of 2004. That's when the Victorian Order of Nurses, beloved in the Niagara region, after 80 years of service lost its contract for providing home care services.

The VON lost this contract because the community care access centre awarded it to a lower bidder: a company with no previous local experience, a company with no staff, and a company with even no office. The community was up in arms when this news came out. No one could imagine that the Niagara region would be without the little red VON cars, sponsored by local businesses, zipping around and providing home care to patients. They even built a little park in one of the communities to celebrate the history of the VON. You could not open up a newspaper or turn on a radio in the region without hearing about the loss of the Victorian Order of Nurses.

These VON staff, also OPSEU members, were extremely upset by the loss of their livelihoods. One nurse

said that she would rather sell doughnuts at the coffee shop than work for a private health care company. By the way, did I tell you that it was a private, for-profit company that won that lowest bid to provide services in Niagara?

Patients were upset too. Elderly and infirm people do not like change. They do not like it when a new person shows up instead of the person they know. They particularly do not like it when nobody shows up, which happened in a number of cases. So that's what happens with competitive bidding.

Concerned members of the community—OPSEU members, patients, the VON, the Niagara media—all asked Minister George Smitherman for a meeting. George Smitherman was very polite and basically said, "My hands are tied. The process is legal. There is nothing I can do. Sorry."

This, or a similar scenario, has played out all across Ontario since competitive bidding came in through the CCACs. The highly respected local chapters of the VON and other organizations with long-standing records of care and community service have been driven into bankruptcy by the Harris-Eves and McGuinty governments' policies. This is merely a continuation of those.

I want to ask members of this committee if you can imagine the hardships felt by patients who had interruptions in health care services as a result of the competitive bidding process.

Why are we talking about this in the context of LHINs? Well, the LHINs will open the door to competitive bidding, not just in home care but in hospitals, in long-term care and in many other aspects of health care. The bill may not state that explicitly, but the maintenance of the purchaser-provider model makes it inevitable. The LHINs bill will make it very easy to privatize a service and very difficult to get it back into the public sector.

I remind you that there is nothing innovative about private sector involvement in health care. There is nothing innovative or new about making a profit from people's emergencies, illnesses or injuries. This is not health care reform, as some would have it. True reform of health care is using the revenues of the province on a public, non-profit basis to provide proper health care for everyone in a time-tested model. It is not using taxpayer money to pay profits. Innovation is finding creative ways of looking after one another, not profiting from people in their time of need.

The system we have in place is not broken; it is underfunded. Ontario's hospitals are already very efficient. They have the shortest stays in Canada: an average of 6.6 days. Ontario hospitals treat more patients on an ambulatory basis than any others in Canada and are the most cost-effective. But some people say that the system is broken. They say that we need a regionalized care model even though some of our hospitals are already spread out over huge geographic areas.

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Our belief, and it is shared with our coalition partners, is that the LHINs are merely a smokescreen for the

minister so that he can avoid responsibility for unpopular decisions made in the regions across this province. Once again he will be able to say, "My hands are tied. The process was legal. There's nothing I can do. Sorry," but now on a much larger scale. This spreads right across, beyond home care.

Another related concern is that services will be contracted out of many local communities under the LHINs. The LHINs aren't local. Don't fall into that trap. The average LHIN is roughly the population of Saskatchewan or Manitoba. For that matter, the LHINs are not about integration. Many of the key parts of the health care system are not in the LHINs. How could you forget the gatekeepers of the system: primary care, family health teams and doctors? How could you forget drugs? Pharmaceutical costs made up 16.7% of health care expenditures in 2004. Drug costs are the fastest-growing expenditure in health care, yet pharmaceuticals are left out of the structure.

Members of the committee, I know that you too face competitive bidding for your jobs in 2007. Maybe you don't have any sympathy for the health care workers who have been laid off or those who are facing uncertainty, but remember: When health care workers leave their jobs or are laid off, there may be no one around with the same training and experience to replace them. Remember that when the next virulent disease hits our hospitals. Those who went through the SARS epidemic and know what to do may no longer be working there. Remember that sick and elderly people will suffer.

If you allow the LHINs legislation to proceed as written, this union and our coalition partners will be there to remind users of the health care system, and their families, why they have to travel that extra 100 kilometres for surgery. We will be there to remind families that many health care workers have left their communities, along with their salaries and the services they provide, because of the chaos this bill is creating.

Our members know the health care system. They care deeply about what happens to their patients. They are the experts. Please, as you travel this province, we would ask you to listen to their voices.

We are calling on the government to withdraw this legislation so that it can engage in a proper consultation process on a provincial strategic plan. If enabling legislation is required for that plan, it must include provisions for proper transparency and accountability, and provisions that uphold the fundamental principles of the spirit of medicare, not just the letter of the law. It must stop the transfer of services out of hospitals, which is being done to avoid the coverage of the Canada Health Act.

I will now ask Patty Rout, who is the chair of our health care division, to make her presentation. Then we'll open it up for questions, if we have time.

The Chair: You have three minutes left. Please proceed.

Ms. Patty Rout: Good morning. I am Patty Rout, a lab technologist at Lakeridge hospital in Oshawa and

chair of both the province-wide health care divisional council of OPSEU and the hospital professionals division. I represent health care workers in all areas of health care, and as an OPSEU board member I serve workers in Haliburton, Algonquin Park, Barrie, Orillia, Oshawa, Cobourg and all parts in between. I have travelled this province two winters in a row to discuss the impact of the LHINs with workers whose jobs and patients will be affected. In this capacity, I have been able to hear the concerns of thousands of health care workers about these LHINs. I am pleased to be able to share the views of these workers with this committee.

We are opposed to the regionalization of care when it involves the movement of hospital services from public to private, and from near to far. We oppose keeping services in constant flux, jobs that move from one hospital to another, and the uncertainty and fear that these so-called integrations cause.

In my own region of Durham, I have already seen how amalgamations and regionalized care have threatened our services. The lack of multi-site funding for the hospitals has created huge difficulties for that region. Just take a look at their deficit budget. If you can't manage four or five hospitals, how are you going to manage it in 14 LHINs?

Just before Christmas, we received word that the pediatric unit at the Rouge Valley hospital in Ajax was being closed and that all services were being moved to Scarborough. For families in Ajax, Pickering and points east, this was going to be a huge hardship. The distances aren't large, but it's a major problem for many people. If any of you have driven on the 401, you certainly know what it would be like if you were having a baby and it was 7 o'clock in the morning in Pickering. Who knows? You'd probably have that baby in the car.

Second to that, not everyone has a car. Travelling from Ajax to Scarborough by public transit literally takes you most of the day. That just isn't an option for a sick child. Our hospitals are part of our community; our tax dollars went to build these hospitals; our tax dollars continue to provide service—full service—for hospitals. As a result of this belief, hundreds of patients and workers attended a meeting in December in defence of these services being available locally. Miraculously, the money was found, but the question is, for how long?

Our concern is that this is already happening across the province. Services are being rationed and moved around, such as nuclear medicine, physiotherapy, biomedical, social workers—I could go on and on. With the LHINs in place, this will happen more and more frequently as the LHINs are forced to ration and centralize services and contract out to the lowest bidder. My father used to say, "You get what you pay for." I don't believe that has changed. We can't have two-for-one sales in hospitals.

Ironically, the sector repeatedly targeted by the Minister of Health is hospitals. It is ironic because the hospital sector has been the star performer in Ontario's health care system. Ontario has fewer hospital beds per

capita than any other province. The Hay Group's March, 2004, study also said that Ontario hospitals are more efficient than others in Canada. The report shows that Ontario's hospitals have a lower potential for finding additional savings than others in Canada, which is a reminder of the efficiencies that they already went through.

Once again, our members are being asked to cope with the chaos that has been created when the whole system is amalgamated, merged, transferred—any way they can find to squeeze a dime out of the system. I have not even mentioned the effect of competitive bidding on hospitals; Leah has done that. But home care is simply not a career option anymore for most health care professionals, and that's thanks to the competitive bidding system put in place by Mike Harris.

We don't want to see the same thing in hospitals. We also wonder if this is truly integration or something else. While the government presents the LHINs as a solution to the integration problem within the system, key parts of the system remain outside, and Leah mentioned a few. Here are more examples:

—The ambulance service is outside the LHINs despite all the problems they're having now interfacing with hospitals.

—Public health is left out despite the lessons learned from SARS. My members will tell you that if you went to the Scarborough Hospital right now, it's in a worse situation than it was the day SARS happened there.

—Hospital laboratories are in the LHINs, but private laboratories are not. Strange.

—Psychiatric hospitals run directly by the ministry are out, but the divested ones are in.

—The independent health facilities, a growing area of health care, are run primarily by doctors. Those are out as well.

This government has just approved \$20 million from the feds to go to the independent health care facilities who provide diagnostic imaging such as x-ray, ultrasound and nuclear medicine. Who are they accountable to? Will there be profit made when it should be used for better care?

Another example: The regional laboratory plan for eastern Ontario, known as EORLA, and other similar structures are also out of the LHINs, even though those hospitals provide care for patients and the lab work is done for those hospitals.

How do you integrate a system when you leave so many important services out of it? This inconsistency will mean more fragmentation to communities than presently exists, and ironically, the LHIN legislation actually encourages transfers to these organizations that are outside the LHINs. Was this the intention? I don't know. But for those workers affected, there are many huge questions that have not been answered.

In the last round of hospital restructuring, the Health Services Restructuring Commission recognized the need for a human resource adjustment plan to be negotiated with the unions. This time, there is no human resource

strategy. I attended a LHINs workshop a year and a half ago. That was a priority in the Markham LHIN; it was also a priority in a number of the LHINs, more than not, and yet it was still ignored. There's already a huge retention and recruitment problem for all health professions and others, and this legislation is going to make it worse. We are already wondering who will be working for us when we're 65 or over. I don't think you want me with a crutch, pushing a stretcher down the hall. Constant chaos and threats of amalgamations and transfers do not help. Who is going to relocate—this is the big question—to a remote community when the rumour of having the service transferred to another centre is frequently rumoured? If you want proof of this, just look at what happened at Scarborough General, look at Sarnia with the palliative care, look at nuclear medicine in Oshawa. It goes on and on.

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The province needs to negotiate a human resource adjustment plan now. The government must be willing to substantially fund these plans, and this plan should have, at a minimum, layoff as the last resort, measures to avoid a layoff; voluntary exit opportunities; early retirement options; pension bridging; and retraining options. A transitional fund should be put in place, and a health service training and adjustment panel should be resurrected now, not later.

This legislation must not go forward without a human resource plan. Without health care workers, you have no health care.

The Chair: Okay, we have about nine minutes left, three minutes each, and I'll start with Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I just wanted to make sure, and you've made a joint presentation, so I'm going to address both of you, and whoever wants to answer the question—I'm assuming that you are aware, both of you, of the meetings that have happened with the ministry in terms of the consultation. You've met with the minister a number of times and your organization has been asked for recommendations, so that conversation has been going on for some time. I think it's really important, because obviously you represent people who are on the front line and it's very important that we listen to you, which is why the minister has met with your organization.

I wanted to also make sure that you're aware of the open process that we're requiring LHINs to undergo when they have their meetings; that the meetings will be open in the community, that there will be access by the community to what the LHINs are talking about, what they're planning. There's a section of the bill that specifies community engagement. It's not as specific, perhaps, as some people would want, but what it does is allow for the LHINs to develop their community engagement processes. I think that's important, because each community is going to have to do that differently. You make a comment about the size of the LHINs—

Ms. Casselman: I'm assuming these are questions. Are these questions?

The Chair: Madame, please.

Ms. Wynne: I'm coming to a question. You've made a number of points, Ms. Casselman, and I think it's important that we make sure you understand the issues.

Ms. Casselman: I know that the minister's staff have given you some questions to ask, so I'm just waiting for them.

Ms. Wynne: No. Actually the minister's staff didn't give me questions to ask.

The last point I wanted to make is that you make a statement about not fixing what's not broken, and I guess it's a little surprising to me that you—especially people who are on the front line—wouldn't feel that there is room for improvement, that there's a need to improve the health care system in Ontario, especially people who have been involved in acute disease and epidemic, that you understand that there needs to be improved communication and there needs to be a plan. Could you let us know exactly what changes you would make in order to make the health care system more coherent?

Ms. Casselman: Yes. I think that's part of our presentation. I'll just start by saying, never open up a question with "assume," because we know what "assume" means, right?

On the consultation, we met with the minister himself and the ministry staff on a couple of occasions. The first time we met with the minister, we said, "Okay, where's your human resource plan?" He said, "My what?" and we went, "Uh-oh." We actually came back on a couple of occasions with the good, the bad and the ugly of Bill 36, what worked, what didn't work, and then we found out from subsequent meetings that that side of the equation had been moved over to the Ministry of Labour. Yet we see very little of it in the legislation, even though, apparently, the Ministry of Labour was involved in the drafting.

On the openness piece, I guess it depends on what kind of openness you're talking about. I'm not quite sure what kind of openness there would be for the folks in Peterborough when they're connected to a LHIN in Scarborough. I think they're kind of outnumbered. On the information and openness of the meetings, whether or not the mostly retirement community could travel to wherever that LHIN is going to be that's attached to Scarborough, it may be a little difficult for the constituents in that area.

What's not broken? If we, God forbid, have another SARS in Toronto, where does the public health department go to? To which of the four or five LHINs that they're now connected—where do they go to find out how they coordinate an attack on whatever that disease will be, because of course there will be another one. You had district health councils where communities and municipalities had a seat. You had Ministry of Health offices. If you just wanted to make sure you were devolving more authority or responsibility away from the central ministry, you could have beefed up those areas, because they were already in the communities, already staffed with qualified folks who knew the health care system—

Ms. Wynne: And many of those will be involved with the LHINs.

Ms. Casselman: Now you're hiring guys in from London who are over here, I guess, for a reason: to look at our health care system. Having been in England in September, we don't want to duplicate what they're doing over there.

The Chair: Ms. Witmer, please; three minutes.

Mrs. Witmer: Thank you very much for your presentation. It certainly is very honest and frank, and I have to compliment you on the courage to come forward and express those concerns.

Ms. Casselman: I've never been shy.

Mrs. Witmer: I know that, Leah, and I do appreciate that.

Maybe you want to expand on the fact that the LHINs are not local. That's a concern that I've certainly had. You've pointed out that the average size is going to be the population of Saskatchewan or Manitoba. What impact do you think that's going to have on decision-making?

Ms. Casselman: I think it'll be totally left in the hands of whoever is being appointed by the minister and whoever they end up hiring. I don't believe—whether there are open meetings. And we still don't know how open they're going to be and what kind of input local folks can have when you're travelling from Timmins to Sudbury to Wawa. If you've got issues with the health care being provided in your community, whether it's aboriginal health care services because the population is higher or whether—again, I come back to Peterborough and Scarborough. Give me a break. What are the connections between Haliburton and Peterborough and the health care requirements in Scarborough? So having the size and the volume when you already had district health councils with local communities involved and that kind of stuff, and you had Ministry of Health offices in those communities—I think we're losing an opportunity here to really make a health care system that is going to work for local people.

The Chair: Thank you. Ms. Martel.

Ms. Martel: Thank you very much, both of you, for being here today. Let me focus on local control, because you referenced that it was your staff who have become the first casualty of LHINs. Yet the minister would like to say that the LHINs are all about input and consultation at the community level. If you look at the legislation, it's clear that it's cabinet that creates, amalgamates, dissolves and divides the LHINs. It's cabinet that appoints the LHIN board members; they don't come from the community at all. They serve at the behest of the ministry. They're even explicitly defined as agents of the crown in the legislation. Each of the LHINs has to enter into accountability agreements with the ministry, and if they can't agree, the minister can set the terms of those agreements. They're funded on the terms and conditions that the minister considers appropriate. The list goes on and on.

So in terms of community involvement, these folks—the cabinet, the minister and the LHINs—have even more

control than what we saw before with respect to, for example, the Health Services Restructuring Commission. I think they're going to be a front for government decisions, negative ones, in the same way that the Health Services Restructuring Commission was. I wonder if you want to comment on that.

Secondly, can you comment on how your own members who were at the Ministry of Health doing health planning, who were involved in the community, feel now that basically their jobs have been lost to the LHINs?

Ms. Casselman: Well, I have to make a pitch for successor rights, because this government has promised to give back what the Tories took away, and we're still waiting. So maybe they would have had an opportunity to move their skills and ability to the LHINs. I don't know whether that would apply. If they had had successor rights they would have been able to at least stay in the ministry. So that's now lost to us as citizens, their work, because those folks are gone; they don't have the ability to stay.

In relation to, again, the local control and input, we don't see it. That expertise is lost to us as taxpayers from those folks who are gone, and the fact that these appointments are made by the government. It's merely—as I'm known to say—a prophylactic protection for the minister in regard to very difficult decisions that they're going to be making in cutting and moving health care services out from under the protection of the Canada Health Act. The more they can divest and devolve out of hospitals and the communities, we're going to see more and more competitive bidding set up, as we see in the home care sector under the community care access centres. And the fact that these are appointed and are not accountable to the communities where they live, I think, is going to be a real disservice to us as taxpayers for our Canadian health care system, our medicare system.

The Chair: Thank you for your answers and your comments.

Ms. Casselman: Thank you very much.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 815

The Chair: We'll move on to the Canadian Union of Public Employees, local 815.

Mr. Perry Levac: Good morning, ladies and gentlemen. This is actually my first time ever doing anything like this, so I'm kind of beyond myself here. My name is Perry Levac. I'm a steward with CUPE local 815. I'm an electrician at the Oakville and Milton hospitals. I'm here regarding Bill 36, or as some people have been calling it, the LHINs. I'm going to try to keep this simple and fast, basically a brief outline. The main thing is that I wanted to come out and make a point so that you people are aware that there is a lot out there that people don't know, that they should be made aware of.

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There are a lot of people out there who don't know anything about the LHINs or how they will affect them. I

was one of the lucky ones who had the opportunity to find out about Bill 36, and I've been telling everyone I can possibly find.

How can you think of putting through such an important bill that affects so many people, and yet the public has so little input? I've been doing a lot of reading about Bill 36, and to be frank with you, it scares the pants off me. From what I understand, a lot of jobs will be affected in order for this to work. And yes, I will be one of the people who lose their jobs, but not right away.

The part that scares me the most is the whole set-up, with the lowest bidder getting the work. I have been in construction for over 20 years and I am sure it will end up, just like the construction industry, with shortcuts and many secrets in order to save money and time and will in the end, result in careless errors, which in turn hurt and cost lives or more money. You can't have a good health care system if every two years you put part of your operation out to tender to keep the price down. This will mean many changes to staff and loss of knowledge for that site. I know that I would not appreciate the lowest bidder doing surgery on me. Would you?

There is a lot to know about LHINs, and there are many questions that need to be asked and answered. There is a lot here, and this whole process has gone way too fast, and too secretively, for it to be a good thing.

Quick; simple. Thank you very much, people.

The Chair: Thank you. Just wait there in case there are any questions for you. Next would be Mr. Arnott, please. There is lots of time.

Mr. Arnott: You did a great job on your first presentation to a standing committee. I hope you'll come back again in the future if you have concerns about legislation. You were concise and straightforward and your point was made loud and clear. We appreciate your input.

The Chair: Madame Martel.

Ms. Martel: Thank you, Mr. Levac, for coming this morning. You're an electrician?

Mr. Levac: Yes.

Ms. Martel: In which hospital?

Mr. Levac: I'm the electrician for the Oakville and Milton hospital sites.

Ms. Martel: And you've been doing that for the past 20 years?

Mr. Levac: No. I've been in the construction trade for the last 20 years. I've been in and out of the Oakville and Milton hospitals, doing work for the last 15 years. I've been employed by Halton Healthcare for the last three and a half years.

Ms. Martel: Halton Healthcare—correct me if I'm wrong—has been expressing concerns about their financial ability to manage a number of sites and whether or not they're receiving appropriate funding to allow them to do that. Or do you know?

Mr. Levac: I don't quite understand the question.

Ms. Martel: It was in the back of my mind, because you're working at a couple of different sites and working for Halton Healthcare, that they actually manage—not manage; run, operate, oversee—a couple of hospital sites.

At previous public hearings they have come before us to suggest that their need to have to manage a number of sites is not taken into account by the government, that the money they get to do that doesn't really cover all their costs, so they are continually looking for ways and means to cut services in order to balance their budgets. I don't know if that is the case, if we've got the right health care group or what the situation is in terms of the hospitals that you're working in now with respect to both deficits and cost-cutting measures, and how much of that would actually be shared with staff like yourself, for example.

Mr. Levac: I really can't answer that question. The only thing I can really talk about is past experience working at the two hospital sites. The workload for me: There is one electrician for two hospitals, so I'm constantly bouncing back and forth from site to site. But as far as the money aspect, ever since day one that I've been down there, I have been asking for another electrician. Finally, down at the Milton site they are going to be losing a plant technician and getting another electrician to help me out down there. That's about the best way I can answer that question.

Ms. Martel: All right. Thank you.

The Chair: Ms. Wynne, please.

Ms. Wynne: Mr. Levac, thanks for coming.

First of all, I just wanted to give you a piece of information, and then I had a question. One of the reasons we're having seven days of hearings rather than two or three or four is that we wanted to get as many people to be able to talk to us as possible. I just wanted to make that clear. There was a large number of people who wanted to speak to this bill, so we've tried to accommodate as many as possible.

You made a comment about losing your job as a result of Bill 36. Have you been told you're going to lose your job?

Mr. Levac: No, I have not been told that I will be losing my job. It is just an assumption, but since I am part of the support staff at the sites, it only makes sense that the support staff would be contracted out.

Ms. Wynne: I think that's part of what's going on here, that there are people spreading that kind of information that is not based on anything that's in this bill, particularly. So I think we need to be clear, as the government to a citizen, that it's not our intention that you would lose your job; it's our intention that health care would be better coordinated in the province. That's what this bill is about. So to the extent that we can make that happen and you can keep your job, then we will be successful.

I just want to be clear that there are different stories going around, and it's in the best interests of people who are opposed to change and opposed to rationalization and coordination of the health system to get people like you worked up about losing their jobs, when that may not at all be what's going to happen. And I hope it's not what happens. So I just want to make that clear.

Mr. Levac: Well, the losing my job part is actually the smallest part of it all. It was more or less the subcontracting. Unfortunately, I'm not a very healthy person

and my wife is not a very healthy person. The one disadvantage—let's say I did happen to lose my job, or somebody in a situation like me who doesn't have half-decent benefits, where they have to dish out more money in order to even pay for their medicines. I don't think that's a proper thing. I think there are a lot of things that haven't been answered.

I read the bill as much as I can. Unfortunately, I don't know that much about politics to understand the bill properly, but there are certainly a lot of questions in there that I think really do need to be answered.

Ms. Wynne: There's nothing in the bill that would instruct any organization to contract out your service or set up a situation where you would lose your job. I hope that doesn't happen. Thank you for coming.

The Chair: Thank you very much for your presentation.

ONTARIO FEDERATION OF UNION RETIREES

The Chair: We'll be hearing the last one before the break for today, and that is from the Ontario Federation of Union Retirees. Joyce—please have a seat, both of you. Good morning.

Ms. Joyce Cruickshank: Good morning. The last name really isn't as difficult as it looks. It's Cruickshank. With me is Orville Thacker. He's the president of our organization.

Mr. Orville Thacker: The reason Joyce and I are appearing here this morning is that we're very concerned about health care. I think the various levels of government have given us enough reasons that we should be very concerned. Not even two years ago, the Prime Minister of the day and the Premiers met, and they were going to cure health care for the next decade. The Premier of Ontario was a party to that group.

We just went through a federal election campaign, and the main thing in those discussions was the deterioration of our health care.

Joyce and I are both volunteers. I'm the president of the federation of union retirees, and Joyce is the secretary. We're not appearing here because we're going to lose our jobs. We're concerned about people who may be losing their jobs, but overall we're concerned about health care and the condition it's in in this province.

Joyce is going to present our paper, and we'll be available to answer any questions you have at the end.

Ms. Cruickshank: Good morning, everyone. Our particular organization has affiliations in Ontario from over 35 organizations, which represents, of course, thousands of retired union members in the province of Ontario. Our affiliates come from many union organizations across the province: Steelworkers Organization of Active Retirees, also called SOAR; the Canadian Union of Public Employees; auto workers by the hundreds, that's for sure; Communications, Energy and Paperworkers; COPE, the Canadian Office and Professional Employees; and the list goes on and on. We are directly

affiliated with the Canadian Labour Congress and with the Congress of Union Retirees of Canada, also called CURC.

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Our constitution has a number of things that it mandates us to do and, of course, one of those is to secure and protect Ontario retirees' mutual welfare, benefits and all those things that accrue to their families by whatever means we can. We believe that there are legitimate aspirations of those who work very hard for a living, and you've heard many of them today.

Our health care system is the cornerstone of our existence. As seniors and retirees, you can probably understand that. We're committed to informing you of our concerns around Bill 36. We believe very firmly in the five principles of the Canada Health Act: accessibility, affordability, public funding, public administration and not-for-profit status—we can't say that strongly enough. We strongly support the Ontario Health Coalition's position regarding Bill 36. I understand that they're presenting to you this afternoon in a great deal of detail, so rather than reiterate all of their points, we'll refer to some and then try to relate it to our own particular experience as citizens, retirees and former union members.

We feel that the bill is a health restructuring bill at heart, no matter how you look at it, but without the checks and balances in place needed to make it responsive to Ontario citizens' needs in health care. In the last round of restructuring, we got hit pretty hard as well. There were hospital closures in a lot of places, staff layoffs, funding shortfalls—we had an awful time. I guess you've heard this from a lot of communities here.

Although we're a provincial organization, most of our experiences that we would relate to you today would come from Waterloo region. Our population is nearing the 500,000 mark and it's growing in leaps and bounds. During the time of the hospital restructuring, we had three acute care hospitals. Down came the mandate that one of them would close. That was St. Mary's Hospital. The time, the energy and the resources committed to trying to keep that hospital open were just phenomenal. Just think of what they could have done if they'd been able to direct that towards improving things at the hospital instead of trying to convince the government that it was a wrong-headed move in the first place.

In our region, in regard to seniors' services, the lack of long-term-care beds and nursing home beds means stressed-out caregivers, and most of these, of course, are women; they're just right at the bottom. I know one of these ladies personally, and when I see her several times a week, I just look at her face and I can see she's had, as usual, about three hours' sleep a night. She's waiting for a long-term-care bed; she said that they told her it would be a year. That kind of stress on ordinary people is just unbelievable, and they're doing this at a risk to their own health and well-being; they're carrying the burden. Is this the kind of end you'd want for your own parents? I can honestly say I would think that you wouldn't.

In Sudbury, some seniors are being sent as far away as Parry Sound for long-term-care placement, which is completely unworkable. How can family members visit at such a distance, even supposing they have their own transportation? How are their doctors going to see them, or are they just shifted off to somebody else who doesn't really know them? How are their ties to their home community maintained? If they refuse this distance placement, does their name go back down to the bottom of the list and they start all over again with the wait?

We do not agree with the centralization of power towards Queen's Park, with the LHINs reporting directly to the minister. Any organization that controls the health system in an area should be responsible not only to the government but also to the citizens that live in that particular area. I understand that members of LHINs are going to be appointed by and responsible to the government. There is a definite lack of democracy there. Who said that they should be picked in that manner? There should be some other way to do it.

Political appointees do not necessarily have the best interests of their assigned community at heart. We saw that in the decision to close St. Mary's. As well, the tendency to appoint those with little or no background in public health care delivery is dangerous. Business appointments are, by their very nature, inclined to look at the bottom line of dollars and cents, profit and loss, and that makes perfect sense to me, but not to a health care system.

We find it difficult to reconcile this mentality with a system that is supposedly designed to answer the health needs of its citizens, heal them, cure them, rehabilitate them and maintain their good health. You may be saying, "Trust us to do the right thing," but we have a problem with that in Waterloo region. A funding promise made to Cambridge Memorial Hospital by the former Conservative government was broken by the current Liberal government. The hospital's need for immediate funding for a new roof and boiler replacement were only the most pressing problems. Many individuals and organizations in the community were outraged and again had to put tremendous time, effort, energy, money, talent and dollars into reversing a stupid decision. Yes, they did reverse it, but talk about effort and energy—wow. It was crazy. The people did it, but they shouldn't have had to.

The fact that LHINs will be able to meet in camera at the discretion of the cabinet flies in the face of what should be an open, democratic process. Decisions about our health care system are far too important to be made in secret, with no input from the public and no right to appeal those decisions by either patients or community members.

In the area of privatization: Again, we do not want our publicly funded health care system to be privatized—not any part of it. We only have to look south of the border to see what a market-driven health care system looks like and to see the millions of ordinary Americans without any health care at all. Ontarians need and want a system that's not-for-profit, where the bottom line doesn't decide

whether or not you even get treatment, how much treatment, how long, what type. We need a healthy population in Ontario, and moving toward a money-driven system is not really the way to go, in our opinion.

Competitive bidding: We did have a flourishing local Victorian Order of Nurses office and group in our community, but they were drastically downsized by the competitive bidding. Although they paid their nurses a reasonable wage, they were underbid by a for-profit company. Turning every facet of service delivery into dollars and cents consideration means that service providers look only at how much they can make out of a contract, or a contact, not how well the person is recovering, healing or being rehabilitated. Again, health care is too important a public service to be left to business and government.

Competitive bidding for hospitals means that the hospital that provides a service for the least price would get the approval to provide that service. That makes perfect sense, but that's not the way to go. Such consolidation of services may be a cost saving for the system, but the distances people would have to travel to be able to have certain procedures performed would be prohibitive, even supposing they have the ability to get there. The years of fundraising efforts to make sure services are available locally would be absolutely wasted.

In our area, for many years, we have had a lack of mental health services and beds. For a number of years we had a revolving-door system. Patients would go into our only schedule 1 hospital, be assessed and diagnosed there, shipped off to London, turfed out of London after maybe a few days, weeks or months, popped on a bus and sent back home to Kitchener with no real connection to their community. They came back to a community in which they had no job, no home, precious little in the way of resources and maybe some very overstressed family members. Very soon, they would either break the law or wind up back in the crisis clinic and back down to London again. So they just went around and around the system for years and years.

Well, about seven years ago, they started looking at ACTT, which is an assertive community treatment team. We finally did get one, and just this last year we got dollars for a second one. Now, you recall I said that Waterloo region has 500,000 people, or close to it. London's got about six of the darned things. Why? They have the psychiatric hospital there to be able to refer people to.

In Cambridge, they didn't have any kinds of mental health beds for years, and they were promised them in the latest round of restructuring. Of course, part of that funding was for mental health beds, but they're still waiting. They haven't broken the ground for that particular area yet. So we're quite familiar with the idea of essential services being located 100 kilometres away. They just don't work.

Mr. Thacker: Five minutes.

The Chair: Three and a half.

Ms. Cruickshank: I've got about three paragraphs.

Geography: I know that you've heard we were watching in the overflow room about geography from some of the other people. It's crazy to lump our huge—I shouldn't say "huge"; not in terms of Toronto—our large metropolitan area in with some very, very rural areas, and the distances are just incredible. I don't think our health care system can survive another restructuring. Establishing networks to make the system better and healthier, but making the kind of changes you're suggesting, raise some really, really bad questions.

Health care, like water and hydro, is far too important to be left alone in the hands of business and the government. It has to remain with those five principles of the Canada Health Act.

The Chair: Any additional comments?

Mr. Thacker: That completes our presentation. How many minutes did you say we had?

The Chair: We have about three minutes that we can allow the members to ask questions, if you want to.

Mr. Thacker: Well, I suppose that may be the most productive way to go, if we could field some of your questions.

The Chair: Okay, terrific. Could we start with Madame Martel, please? One minute each.

Ms. Martel: Thank you for being here today. The LHIN area that I come from is excessively large: through most of northeastern Ontario and then heading down into southern Ontario. The concern of many of my constituents is that when the minister talks about rationalization or consolidation, he's not just talking backroom services like HR; he's talking centralization of important health care services at one hospital. In our neck of the woods, it would probably be the Sudbury Regional Hospital. I live in Sudbury. One would think I'd be happy with that, because I could benefit from that, or our community could, but there are already people from across northeastern Ontario travelling three and four hours to come for cardiac care, neonatal care, cancer care. The last thing they want to do is have to come for other operations as well because services are rationalized at that single hospital in order to cut costs and everybody just travels to there.

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You said you didn't want to talk very much about geography, but I can tell you that it has lots of significance and lots of resonance in my part of the world in terms of where this is going to take us and what the ministry is really trying to do, which many think is just to find a way to rationalize services and cut some costs. Maybe you want to describe again, from your part of the world, why people would be concerned about travelling perhaps even more than they already do.

Mr. Thacker: That's one of our concerns. If you have business people running these LHINs and they're only concerned about the bottom line, they're going to limit services in certain areas and you're going to have to travel a longer distance to receive them.

I can sympathize with the people in the north. For too long they've been travelling too far for their services, but

even in—if we're used to getting our health care in Kitchener, we see no reason why we should have to travel even to Guelph to get the same services, because it doesn't make sense. You're clogging up very dangerous highways, to begin with. You've got people who are driving on highways under stress. It really isn't a good situation.

That's our main concern: We don't want to see these things run as a business and as profit-motivated.

The Chair: Thank you very much. Ms. Wynne.

Ms. Wynne: One of my and, I know, the minister's concerns when we were first elected was the fact that some of the district health councils did a lot of planning. Certainly the Toronto District Health Council had a pretty good idea of what the services were and what was needed, where the gaps were in Toronto. But nobody really listened to the district health councils, and that was a huge problem.

If you look at the objects of the local health integration network, including "to identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the minister about that system," do you think, at the core, it's a good thing to have a planning body that has some clout in terms of its ability to fill those gaps or make rational something that's not rational in an area?

I take your point about geography. I understand that. Every file in this government, because of the size of Ontario, deals with that issue. I've spent a lot of time in education. Some of the boards in the north are huge. We have that problem in Ontario. That's a given. But given that, is it a good thing to have a planning body that actually has some clout in terms of monitoring and making changes that will provide better service?

Ms. Cruickshank: As a former member of the district health council in our area, and I chaired it for about three and a half years—

Ms. Wynne: And nobody listened to you.

Ms. Cruickshank: —I describe them as toothless bears. They could rage and prance around their cage and show their teeth, but that's all, because there was no legislation that they could point to and say, "Do it, or else."

The bulk of the people on those planning bodies—I shouldn't say the bulk of the people. They did a really good job, but they had a really good understanding of the health care delivery system. Many of them either worked or were former workers within the health care system, so they had some of this understanding. Yes, we need some planning in place and we need the ability to carry out those plans, but I don't think what they're describing here is what Ontario needs.

The Chair: Thank you. Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. As you know, I represent a big part of the rural part of Waterloo region, part of the city of Kitchener, of course, and much of Wellington county. I want to thank you very much for giving voice to some of the concerns

that I hear in my constituency, and especially for your effort to highlight the issue of the Cambridge hospital, because I would agree with you. After a great deal of community response—including a massive petition, trips to Queen's Park by a huge number of people from the Cambridge area, work by the mayor and council and of course the good work of MPP Gerry Martiniuk and Elizabeth Witmer, our health critic—in the end, the government has allowed the hospital to move forward to some degree, although not really the full approval we need.

The fact that you've raised that issue, I think, is something that needs to be brought to the attention of the committee and the government. As we move forward with Bill 36, whatever rationalization and improvement of health care will be taking place, surely we would look to the future with a view to preventing that from happening again in Cambridge.

Do you think this bill should be withdrawn?

Mr. Thacker: First of all, not many citizens of the province know very much about the bill. It was kind of pushed through neat and tidy. I suppose if there wasn't a bit of an uproar from the opposition, we wouldn't even be having these hearings. It probably would have been history by now. I think that's the main problem: that most of the citizens of the province are not aware of what's in this bill or what's going to culminate as a result of this bill.

Mr. Arnott: Yet it would appear that if this bill passes in its current form, there will be a massive change in our administration of health care, and if people don't know about it, they're not going to be able to offer an opinion or provide input.

The Chair: Thank you very much for the presentation and your answers to the questions.

We are ending the first part of the day. We are going to go for a break. We'll be back at 1 o'clock.

The committee recessed from 1156 to 1302.

NOOJIMAWIN HEALTH AUTHORITY

The Chair: Good afternoon and welcome to our afternoon session. The first presentation this afternoon is from Leslie Cochran. Is Leslie here? Would you please have a seat. You will have 15 minutes to make your presentation. You can start any time you're ready. There are 15 minutes in total, and if you spend less than 15 minutes, there will be an opportunity to make some comments or ask some questions.

Ms. Leslie Cochran: My name is Leslie Cochran. I'm a Trent graduate; I graduated in 1999 with honours in native studies. Currently, I'm working as a policy analyst for Noojimawin Health Authority in Toronto. It's a health authority that is funded by the aboriginal healing and wellness strategy. We have a staff of three. We cover the province. We're unique because we're the only health authority mandated to articulate the aboriginal urban and rural health priorities at both the regional and provincial levels. Our activities focus primarily on policy analysis,

aboriginal health research and methodologies, communication, and coordination of services.

Our board is composed of the Ontario Metis Aboriginal Association, the Ontario Native Women's Association, the Metis Nation of Ontario, the Ontario Federation of Indian Friendship Centres, and Anishnabe Health Toronto, which is one of two aboriginal community health centres in the province.

I just want to begin by thanking the committee for opening up public consultation and also acknowledge their support staff for coordinating this series of meetings. I also wish you safety as you travel across the province so that you can return home safely to your families.

My reason for being here today is just to stimulate reflection and further inquiry about Bill 36 as it relates to aboriginal health. As individuals involved in policy development and analysis, we have an important responsibility to ensure the legislation is equitable; specifically, that urban and rural aboriginal people enjoy the same access to health services as the general population and also enjoy equal opportunities with regard to health planning processes and representation.

We know that equal opportunities do not equal the same results, and for this reason we acknowledge that sometimes different processes or treatment are required to achieve the same results. It's this notion of equality that is embedded in the Canadian Charter of Rights and Freedoms.

The health status and health service needs of aboriginal people differ from those of the general population in many ways. While I am conscious that I always try to present a healthy image of aboriginal people, it needs to be said to this committee that differences in life conditions, ongoing systemic discrimination and historical trauma contribute to unbelievable disparities in the experience of health and well-being.

The development, implementation and evaluation of health policies that affect aboriginal people must take these differences into account; if it does not, your analysis is incomplete and unintended impacts will occur.

For this reason, I just want to share with you a health-impact statement with regard to Bill 36 as it relates to urban and rural aboriginal health. First of all, we see that limited consultation processes have effectively shut out some provincial and territorial organizations; effectively, non-status Indians. The effects of the proposed legislation on aboriginal health outcomes, health services and health planning processes have not been identified and addressed. Links have not been made between Bill 36 and existing policies and strategies such as the New Approach to Aboriginal Affairs, the blueprint on aboriginal health, Ontario's aboriginal health policy or the Canada Health Act. Insufficient consideration has been given to the resources needed for addressing aboriginal health in various regions of Ontario and little has been said about how we will retain services in the north. A proposed complementary aboriginal-specific policy or strategy with respect to local health integration networks has been ignored.

My question to this committee then becomes: How do these outcomes meet or hinder the Ontario Liberal government's values, objectives and policies? I don't think people mean to exclude and people don't mean to do a bad job, because when they want to, they do their best. So I'm just here with some reminders that we need to take care as we move forward.

This past summer, the McGuinty government announced Ontario's New Approach to Aboriginal Affairs, which proclaimed this new, constructive, co-operative relationship with aboriginal people, one that was based on mutual trust and respect. It also states that the government is committed to creating a new and positive era in the province's relationships with aboriginal people in all their diversity, and this includes urban and rural. Yet the first real opportunity Ontario has had to demonstrate this new approach, to actually turn it into a practice, has missed its mark.

The preamble in Bill 36 recognizes "the role of First Nations and aboriginal peoples in the planning and delivery of health services in their communities," and then it's never mentioned again. So I question: What exactly is the role of First Nations or provincial-territorial organizations when the government is approaching them only after the fact? The consequence of working in this way continually undermines this relationship we're striving for that was described by the Liberal government in the New Approach. Not only is it frustrating and stressful for government, political staff and aboriginal leadership, but it's inefficient. We are not using our talents to the capacity that we have. It's costly and it's time-consuming. It becomes a scramble for the finish line, to come up with something that is somewhat acceptable to First Nations and aboriginal communities.

The role, if it were truly valued, would be a common thread woven from beginning to end throughout the entire policy process and not merely an afterthought, add-on or additional subsection. There would be an awareness at all levels of government of the importance of aboriginal health as an organizing principle, as a way of conceptualizing information.

If this were the case, Bill 36 would look a lot different. I would actually have confidence that the minister's provincial strategic plan would include aboriginal health priorities; I would have confidence that the performance agreements would inherently include indicators of success—

Feedback from the public announcement system was heard.

Ms. Cochran: Is this normal?

The Chair: Yes, go ahead.

Ms. Cochran: I would have confidence that the performance agreements would inherently include indicators of success around the number of aboriginal community consultations and how they were conducted. I would be confident that the reporting from the LHINs that's being required would have aboriginal-specific data that would let me do my job a whole lot better. I would be confident—

Feedback from the public announcement system was heard.

Ms. Cochran: What is this?

The Chair: The technicians are working on it. If you are able to continue, go ahead; otherwise, wait, and we'll—

Ms. Cochran: What is it? Feedback?

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The Chair: If I knew, there would be no problem. I'm told it's outside.

Ms. Cochran: Okay.

I would also have confidence that aboriginal health professionals, both regulated and non-regulated, would be included in committees, but to date the legislation is quite exclusive.

Ontario has recognized in the New Approach the importance of programs delivered by aboriginal service providers in Ontario. Furthermore, it commits the province to continue partnering with them to support and improve the delivery of these programs, yet there is no clause in Bill 36 which guarantees or protects aboriginal health services from integrating or ceasing to exist.

Feedback from the public announcement system was heard.

Ms. Cochran: Is everybody listening? I don't think you're hearing me.

The Chair: We are trying to fix the problem. It's outside. So we have two choices: one, we wait; or, if you choose, you can continue. Unless somebody objects, you can continue. It's up to you.

Ms. Cochran: Is everybody listening?

The Chair: Yes, we are listening. We are able to hear you.

Ms. Cochran: Okay.

Despite the importance the Liberal government has put on partnering with aboriginal health, there is still no clause in this bill that guarantees that aboriginal health is still going to exist and that you support it.

Shifting gears a little bit, I gave you a copy of the Blueprint, which is the most recent document, which describes a 10-year transformative plan, agreed to by the First Ministers and leaders of national aboriginal organizations, intended to close the gap in health outcomes for aboriginal people.

What I want you to understand is that the Blueprint incorporates three distinct frameworks, as well as commitments to urban and aboriginal concerns with respect to health. It's intended to guide your decision-making, and it's also intended to be implemented at the regional level. All parties, and this includes Ontario, have endorsed this population health approach that focuses on determinants of health, including those outside the formal health sector. In doing so, Ontario has agreed to work with aboriginal organizations and leadership to ensure that the interests of their constituencies are reflected in the health care system, and still there is no clause to guarantee this in Bill 36. I'm just wondering if maybe you can make the connection as a committee to ensure that this is there.

Aboriginal health services in Ontario in urban and rural areas are tailored to the diversity of that community, and they are responsive to the needs of that community. They are specific and effective.

The Blueprint speaks out against pan-Indian services. This is a potential reality under the LHIN structure: that all aboriginal services might get lumped together or that they may somehow be integrated with non-aboriginal services. We need specific services in communities where we have actual nations and populations identified and specific health needs that have been identified. Part of me is wondering if the Blueprint, because the Premier has adopted this, precludes LHINs from even requiring aboriginal health service providers to integrate. Does it supersede this bill? These are the questions you need to answer as a committee.

Alternatively, if we look at it in a positive way, LHINs have a really unique opportunity to implement the Blueprint, to be leaders, to be the first people who are doing this, because we're moving so slowly on this.

When aboriginal communities lack participation, resource support, influence over decision-making and involvement in health-planning processes, programs and services become inappropriate for aboriginal people.

I just wanted to touch on the fact that participation is a difficult thing, because we only have X number of aboriginal professionals who are able to participate at various different levels of health planning. Resource support: How do we get to these meetings? One district reported that a hospital had 72 planning committees. So how do I, with an office of three, try to attend these and influence these? So resource support becomes very important.

The Aboriginal Health Policy, which I've also provided you a copy of, is probably the least-known and most underutilized document in the government at the moment. The Aboriginal Health Policy provides the Ministry of Health with strategic directions when it comes to planning and representation. As long ago as 1997, it recommended a strategy to facilitate First Nations and aboriginal communities' representation and participation on governing bodies for health programs and services to ensure that communities are involved in health planning activities at local, regional and provincial levels. It made recommendations that the representation must be proportionate to the First Nations-aboriginal population or to the aboriginal population being served, whichever is greater. Let's look at the structure of the LHINs right now. Who are our CEOs? Who are our board members? It's not our community. We have communities that are coming close to 51% aboriginal. This needs to change.

It recommended that the Ministry of Health and First Nation-aboriginal communities develop a strategy to support nominations and appointments of aboriginal people to public boards. What happened? Front-line workers were not allowed.

It recommended that a strategy be developed to address and remedy racism and discrimination in public boards. What are we in, 2006, nearly 10 years later?

We have learned a lot from the Bill 36 experience. We've learned a lot about processes and how we fumble through them. We've learned a lot about inclusiveness and the need for it. So the question then becomes: If we're looking for real alternatives for government and aboriginal people, what are our options with this bill? How do we move forward in a way that's mutual?

If the real purpose of this act is to provide for an integrated health system to improve the health of Ontarians through better access to health services, co-ordinated health care and effective and efficient management, from my perspective we've got a long way to go. Effective management. Efficient management. I know that people do their best, but we can do better.

I want to leave you with some key messages today—and I hope you can hear me over the feedback.

Aboriginal health service providers need to be protected from integration orders and protected from ceasing to exist. Communities rely on health services as an integral part of being in that community, and they're a tremendous support towards well-being.

Performance standards for LHINs must include aboriginal community engagement, and it must be deemed useful by the community. I would even argue that those engagement processes should be designed by that community and approved by that community. Where is that in the legislation? If we're really moving forward and uplifting aboriginal health and we're going to change the way we think about it and uplift it so it's a current, concurrent system, these are the ways we can empower each other.

Inclusion of aboriginal leadership throughout the policy development process would lead to more effective and efficient management of the LHINs. Those are the outcomes you've identified. You want efficiency? Then start including people and get them working for you. It's simple.

LHIN representation needs to reflect the constituencies they serve. This is mandated in the aboriginal health policy, and Bill 36 breaches that policy. So I need you to look at the new approach, which I'm sure you're all familiar with. I need you to review the aboriginal health policy, specifically section 3, which talks about planning and representation, and then you need to find out from your Premier which is more important, Bill 36 or the Blueprint, and how these interface and intersect, because that's going to be a big one for you.

I was only here to help you as you move forward in your clause-by-clause reading. I want you to read with a filter, and ask the questions: Is this inclusive? How does this protect aboriginal health? How does this reflect the values of the government that's in power at the moment? Be rigorous. Dare to change and think and act differently. We're on the cusp of a new era. I think this committee has a lot of potential to swing us into action and to move forward in a different way, not because you have this moral sense of obligation but out of an impulse that you want to move towards good government.

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The Chair: Thank you.

Ms. Cochran: Just one more comment. I realize that I'm the first speaker from an aboriginal organization; you'll be hearing from my peers over the course of the next four to eight days, I guess. I've left specific amendments up to the PTOs to put in your ear, but I just really want this committee to think about process and how we can move forward in a better way so we can achieve—there is a common goal here: that Ontarians be healthy and have good access, and this includes urban and rural aboriginal people.

The Chair: Thank you for your presentation. Sorry about the technical problem we're having.

Ms. Cochran: That's okay. It's not your fault.

The Chair: We've never had this in the two-plus years that I've been here. I don't know what the problem really is. But we could hear you, and I suspect that people also were able to hear what you were saying. Your presentation has been appreciated. We certainly went over six minutes because of the noise. Unless there is a strong will to ask questions, I think we can move on to the next presentation. Would that be okay? Thank you again.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 333

The Chair: I'll ask the next presentation, the Ontario Public Service Employees Union, local 333, from Oshawa.

Ms. Maureen Whyte: Good afternoon. My name is Maureen Whyte. I am here today as a representative of OPSEU local 333, and as a concerned citizen. I am employed with the Ministry of Health and Long-Term Care in the claims payment branch. I am responsible for processing doctors' claims submissions for payment, providing customer service to the public on questions of coverage and processing out-of-country medical expenses for patients.

I am here today to voice my adamant and vociferous opposition to the passage of the LHIN legislation, Bill 36. I have several issues with this legislation and the way the government is implementing it.

First of all, I am highly suspicious and very cynical of the implementation process that is unfolding before us. Why is the government so intent on rushing this legislation through? It was introduced just before the Christmas break, when people both in and out of the government are distracted by other issues.

Feedback from the public announcement system was heard.

Ms. Whyte: Fortunately, I talk loud.

The Chair: Could someone go and speak with someone, instead of just sitting here and hoping someone fixes the problem?

The Clerk of the Committee (Ms. Anne Stokes): There are people working on it.

The Chair: So you know they're working on it.

The Clerk of the Committee: Yes.

The Chair: I guess you have the same choice as the prior speaker. I can hear you properly. Unless somebody has a problem, I think you can proceed.

Ms. Whyte: Carry on? Okay. The bill has gone through second reading and there has yet to be any serious discussion, debate or consultation in the house or with many of the stakeholders, our unions among them. I attended one of the public forums that was held to inform communities about this initiative. I dare say that I, along with many other participants, left with more questions than answers.

The LHINs are charged with implementing the government's strategic plan for health care, which has yet to be developed or unveiled. Is this not a case of putting the cart before the horse? Further to this, the LHIN boards were established before there was any framework, guideline or legislation that would provide them with their mandate.

The government has also deemed it necessary to totally disband the district health councils, which the LHINs are replacing. Is this not throwing the baby out with bathwater? Would it not have made more sense, and been more cost-efficient, to build on the experience, expertise and success of an already existing structure?

And for an initiative that is supposed to reduce health care costs, thus far it is doing anything but. By the government's own figures, it is costing twice as much to administer the LHINs as it did the district health councils. This year \$40 million is being allocated for the administration of the LHINs versus \$18 million to \$19 million for the district health councils. It's also costing somewhere in the neighbourhood of \$20 million to dismantle the district health councils.

The necessity of creating such an unwieldy and expensive bureaucracy is something else I question. Many of the things that LHINs are charged with doing under Bill 36 are being done elsewhere, without the creation of an additional and unnecessary layer of bureaucracy. The consolidation of many of the payment and accounting systems within the government, and bulk purchasing agreements by hospitals—just two examples—are already being implemented in areas outside the LHIN jurisdictions, and it didn't involve the creation of huge appointed, unaccountable bureaucracies. So why is it necessary to create this expensive and unaccountable layer of red tape here?

My, and many other people's, feelings are that it's an attempt by the government to remove itself from the inevitable fallout of unpleasant political decisions made by the LHINs, which leads me to my next objection: The LHINs are being given massive decision-making authority and almost two thirds of the provincial health budget. The legislation states that they will be accountable to the Minister of Health. These are unelected, appointed positions spending the taxpayers' money with seemingly no accountability to anyone but the Minister of Health.

Under the legislation, the LHINs are given a mandate to integrate, amalgamate, consolidate etc. I have to

wonder if many of the savings that will supposedly be realized by the LHINs won't be eaten up by legal challenges under the Charter of Rights and the Canada Health Act. This would occur as the inevitable centralization and regionalization of health care under LHINs leads to reduced accessibility, one of the principles of the Canada Health Act. Or will the LHINs circumvent the Canada Health Act by introducing competitive bidding and private contractors which are outside its jurisdiction?

In addition to the huge cost of implementing and administering the LHINs, the larger social cost and economic impact on many communities must be considered. In their zeal to integrate, amalgamate and rationalize, the government must realize that the health care sector is the cornerstone of many communities' economies. If this sector is devastated by job and wage cuts, in some communities the ripple effect to other businesses could destroy their economic health and vitality.

In closing, I would like to say that until there has been full disclosure as to the intent and mandate of the LHINs, until there has been real consultation and collaboration with all stakeholders and until the necessity and the real cost and viability of the LHIN model have been explored, this approach should be stopped. As taxpaying citizens in a democratic society, we are entitled to complete and comprehensive information, including total costs, so that we may make an informed decision on whether this is necessary and/or even a viable option.

I believe that such a fundamental and far-reaching initiative that represents such a massive sea change in the way health care is delivered requires far more input and far more debate from all those affected. At the very least, I think opinion polls and focus groups should be conducted and maybe even a referendum considered. Legislation such as this that has such potential for adverse impact on people's jobs, lives and their communities requires far greater scrutiny.

The Chair: I'm sorry for the noise that we're all experiencing. We have about four and a half minutes left, one minute and a half, each. Ms. Wynne, please.

Ms. Wynne: Thanks, Maureen. On the issue of the district health councils: You talked about their existence. One of the concerns about district health councils is that they were bodies that did a lot of planning, but they really didn't have any teeth; there wasn't any way of their plans being put into operation. If you read the objects of the LHIN under section 5, I think it's clear what the purpose of the LHIN will be: "(a) to promote the integration"; "(b) to identify and plan for the health service needs." There are 12 items there, actually, under part II, section 5.

I guess my fundamental question is, is it a good idea to have a body in place that will be doing the planning, the kind of thing the district health council was doing, but on a broader basis, and will be able, then, to fund and to bring together disparate services and integrate them in order to provide the best service to patients? Is that a good idea at its base?

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Ms. Whyte: It may be. The big issue I have with it is that the government has not been terribly forthcoming with information about the LHINs. The consultation process seems to be kind of after the fact. From participants—

Ms. Wynne: Sorry to interrupt you, but those 4,000 people who took part in the open houses and were able to attend meetings at the beginning of this process—you don't think they got information? Certainly people in my community got information. They brought it back to my seniors' council and we were talking about what they had heard.

Ms. Whyte: The feedback I've gotten is that many of those public meetings were a bit of a waste of time. The one that I attended, although it did provide some information, I don't feel it provided enough information to make an informed decision. The real issue I have is the fact that these are appointed boards. They are unelected; they are being given two thirds of the health benefit, to my understanding. Who are they accountable to? The Minister of Health.

The Chair: Thank you. Mr. Arnott.

Mr. Arnott: Thank you very much for your thoughtful presentation. You mentioned the administrative costs that are going to be incurred by the government because of the disbanding of the district health councils and the establishment of the new LHINs. You indicated that you feel the establishment of the LHINs is really an effort by the government to create a political buffer so as to insulate the minister from—

Feedback from the public announcement system was heard.

The Chair: Please proceed.

Mr. Arnott: I certainly concur with you that that is one of the reasons, it appears, that the government is coming forward with this legislation.

The thing that strikes me as being most problematic is the fact that the government proceeded to establish the LHINs in the absence of any legislative authority to do so.

Ms. Whyte: Exactly; precisely.

Mr. Arnott: One might argue that that demonstrates absolute indifference to the Legislature and the role of the Legislative Assembly.

Ms. Whyte: Exactly.

Feedback from the public announcement system was heard.

The Chair: I wonder if somebody can go and tell those people that there's no need to waste more time telling us. Can somebody do that, please? Ted, sorry; go ahead.

Mr. Arnott: Would you care to respond?

Ms. Whyte: I would agree wholeheartedly with you. That is exactly my fear, that they're circumventing the entire democratic process. I want our elected officials to be accountable for the money and the decision-making process. That's why I vote; that's why we elected them; that's why we have a democracy. I don't like the idea of

huge amounts of money being placed in the hands of people who are appointed, who are not accountable to the taxpaying citizens. We don't even know what their mandate is. How can I make an informed decision about this? There's no legislation; there's no framework; there are no guidelines. When these people were chosen and this was set up, they didn't have a job but they were being paid. The system is backwards.

The Chair: Ms. Martel.

Ms. Martel: Thank you, Maureen, for being here today and for trying to operate over the fire alarm system.

At the start, you said it was interesting that the mandate of the LHINs is to implement the government's strategic plan, which hasn't even been developed yet. It is astonishing to me that this can be a mandate when we have absolutely no clue when the government is going to get around to implementing its own plan: who is participating, what the process is for that, etc. There's something a bit backwards about all of this.

I should have asked Leah Casselman earlier, but you said you had attended some of the meetings. Do you have any sense that OPSEU, for example, which represents thousands of workers in this sector, has been asked to participate in the making of a strategic plan at the provincial level? Do you have any sense of what's happening with that, what the process is, who is involved?

Ms. Whyte: My counterparts in the union who I have talked to—this has been one of the major complaints—have not had any real involvement in the process up until this point. They have tried to make their concerns and their issues known to the government but they have been largely ignored. Their issues and concerns have been ignored and they have not been invited to participate in the process. That's my understanding in talking to my colleagues. I have not had an opportunity to participate in those meetings, but that is what I've been told.

The Chair: Thanks very much. For those of you who are worried that we won't be able to appreciate what you are saying, that level of noise does happen in the House sometimes, so we are used to it.

CENTRAL LHIN HOSPITALS

The Chair: Can we have the next presentation, the Central LHIN from Richmond Hill, Mr. Weldon, please? That doesn't happen in Richmond Hill; I know that.

Mr. David Weldon: Mr. Chairman and members of the committee, thank you very much for taking the time to hear from us. My name is Dave Weldon. I'm the chair of the board of York Central Hospital. I'm here today to speak on behalf of the nine hospitals that are located within the boundaries of the Central LHIN. Those hospitals are Bloorview Macmillan Children's Centre, Humber River Regional, Markham Stouffville Hospital and the Uxbridge Cottage Hospital, North York General, Shouldice, Southlake Regional, St. John's Rehab, Stevenson Memorial and York Central.

We are thankful that we have this opportunity to present to you today as part of this consultation process

and we are mindful that consultation is the hallmark of the democratic society we live in.

We are the boards and management of the Central LHIN hospitals, and we applaud the Ontario government's commitment to improved health care through better access, coordination of care and effective and efficient management. We look forward to participating in the Central LHIN, and more specifically to working co-operatively with other hospitals and health care providers: to facilitate care across the continuum; to improve patient access to services; to provide care in the most appropriate and cost-effective setting; and to reduce overlaps and duplication of services.

We support the overarching principles of Bill 36, and the acknowledgement that a community's health needs and priorities are best developed by health care providers and the people they serve. We endorse the government's commitment to:

- enable local communities to make decisions about their health system;

- work together with communities, health care service providers and LHINs to better co-ordinate health service delivery across the province;

- equity and respect for diversity in communities;

- public accountability and transparency;

- govern and manage the health system in a way that reflects the public interests and promotes efficient delivery of high-quality service;

- ensure that access to health services will not be limited to the geographic area of the LHIN in which one lives; and

- deliver the health service that people need, now and in the future.

We support the key principles of the Canada Health Act and the work of the health quality council. We actively participate in the development of hospital accountability agreements for our member hospitals.

A little bit of background about the Central LHIN hospitals: We have a tradition of accountability and efficiency. The Central LHIN hospitals proudly participated in many initiatives which demonstrate leadership in public accountability, including:

- voluntary participation since 1998 in the balanced scorecard, a joint initiative of the Ontario Hospital Association and the Ministry of Health and Long-Term Care;

- a tradition of community stewardship and accountability through their hospital, foundation and volunteer association boards; and

- support of the multi-year funding guidelines and hospital accountability agreements and the continuing work of the joint policy and planning committee to develop an improved funding formula for hospitals.

Central LHIN hospitals have embraced measures to reduce waiting times for key surgical and diagnostic procedures, demonstrating the ability to become some of the province's top performers in several areas. In the material that has been circulated, there are a number of graphs, the first being hip surgery, demonstrating median

wait times in October and November 2005. Of the five hospitals that are involved in hip surgery in our LHIN, three are below the Ontario average in wait times; for knee surgery, three of the five are below the Ontario average; and three of the six that provide cataract surgery are below the average. We are working very hard and very productively in keeping wait times low.

Some key facts about the Central LHIN: It has the largest population of any of the LHINs in Ontario. It represents 12.5% of Ontario's population. Currently, a total of a little over 1.5 million people live in the Central LHIN. It has one of the highest growth rates. The graph on page 5 indicates our growth rate at 14% projected between 2007 and 2012, and historically, certainly over the last 10 years, it has been the highest in the province. The provincial average projection is 10%, so we're 40% higher than the provincial average. It has the highest proportion of immigrants—new immigrants and visible minorities—in Ontario, almost double the average. Central LHIN has about 45% of its population in that category. It has one of the lowest localization index scores in the province, indicating that a high number of our residents are seeking health services outside of their LHIN. The percentage in our LHIN is around 60%; the provincial average is around 80%. It has one of the highest proportions of low-income households in Ontario. Despite some of the perception that parts of our LHIN are amongst the wealthiest, we have one of the highest proportions of low-income households in Ontario, second-highest to the Toronto central region.

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The map attached to our presentation sets out the boundary of our LHIN, and you can see that it is quite large. Forty-four per cent of our population lives in the city of Toronto, and 56% in York region and parts of Simcoe county. An estimated 40% of the patients served by the Central LHIN hospitals live outside of the Central LHIN boundaries. Our age-weighted growth rate is higher than most in Ontario, and the York region proportion of that is significantly higher than the Central LHIN average. Most of the growth in the Central LHIN is taking place in York region. York region continues to grow at a rate faster than that of any other LHIN.

There are a number of service providers in the Central LHIN: nine hospitals; 42 long-term-care facilities; 43 community support service agencies; 27 mental health organizations; seven addiction organizations; four community health centres, with one to be added in Vaughan; two CCACs; and three other acute providers. There are 125 health care organizations in total. Some of them are represented in more than one of the categories listed above.

As I said at the beginning, we generally support the provisions of Bill 36. We do have six areas of major concern.

The first is, in our minds, the need for population-based funding. There is a need to include consideration and recognize population size and characteristics in planning for health service needs of communities served

by the LHIN. Currently, hospital funding is based largely on historical capacity and funding and it does not address physical capacity, human resource and funding restrictions which may be creating unacceptable wait times, or causing residents to seek care outside of their LHIN. This approach is particularly problematic for high-growth communities that have been historically underfunded in both operational and capital funding. Therefore we strongly recommend that the funding formula for both hospitals and the entire LHIN be directly linked to growth.

Secondly, funding and planning mechanisms to recognize cross-border patient traffic. Currently, the legislation empowers LHINs to allocate and provide funding to providers of services in or for the geographic area of the LHIN on terms the LHIN considers appropriate. A significant proportion, up to 40% for community hospitals such as Humber River Regional, North York General and Markham Stouffville, and higher for specialty hospitals such as Shouldice and St. John's Rehab, of the hospital service areas lie outside of the geographic boundaries defined by their LHIN.

The legislation should articulate guiding principles regarding funding to providers, which include: (1) equitable access to the continuum of care and meeting health care needs; (2) effective, high-quality care; (3) overall cost containment; (4) operation efficiency within the context of value for money; (5) equitable and transparent allocation of funds; (6) stability and predictability in provider operations; (7) consistency with the IHSP and provider roles; and finally, provincial standards.

The legislation should also clearly identify how these principles will transcend the geographic boundaries of individual LHINs to respect patient choice and preserve access to care. We firmly believe that there needs to be something in the legislation that will help us all understand how that will work.

Thirdly, the selection of LHIN board members and clarification of criteria for in camera board meetings is a concern. There is a lack of clarity in the selection criteria for the LHIN boards to ensure appropriate skill-based local representation from within the LHIN boundaries. In keeping with the overarching principles of bringing decision-making and accountability closer to the point of service, there should be explicit direction within the legislation to ensure appropriate local representation on LHIN boards by those who either reside or work within the designated LHIN boundaries and have appropriate and clearly identified skill requirements. Further clarity is also needed in specifying the process by which board members are appointed.

Although the need for LHIN board meetings to be open to the public is specified in the legislation, there are no specifically defined parameters for in camera discussions. Clarifying these parameters within the legislation would ensure transparency and create confidence in the integrity of the board and its decision-making processes.

The next item is criteria for integration decisions and appropriate appeal mechanisms. Our concern is the need

to more clearly define the criteria for integration decisions and the mechanism of appeal regarding these decisions. Integration decisions should be evidence-based, consistent with the provincial and/or LHIN plan and shown to be in the public interest.

Currently, there are no clearly defined criteria for integration decisions, and appeals are heard only by the LHIN board that issues the decisions. Appeals, in our view, should be heard and ruled upon by an independent third party that is outside the political or bureaucratic realm of influence. This would ensure proper recourse and redress for integration decisions made on incorrect information and safeguard against inappropriate interference in the process.

The next item is the preservation of foundation independence and donor privacy. The proposed legislation expands the reporting requirements of hospital foundations to include the LHIN to which their affiliated hospitals report. Currently, only the hospital foundations and hospital boards receive these reports from foundations and have the ability to influence how the funds will be directed. Quite frankly, sometimes we don't. We get a number of people who make donations to our foundations, and those donations are made for specific purposes that they themselves want to see enhanced. As separate legal entities, foundations do not fall within the scope of the LHIN. Therefore, the subsection of Bill 36 that speaks to this new reporting requirement and amends the Public Hospitals Act to recognize this reporting relationship should, in our view, be deleted. This amendment to the proposed legislation would help preserve both foundation independence and also donor information included in their reports.

There also needs to be a clear definition of "public interest." There is lack of clarity with regard to the definition of "public interest" in the bill, in our minds. The LHINs and the minister must consider the public interest when issuing integration decisions or orders, but the legislation does not provide a definition of "public interest," as does the Public Hospitals Act, PHA, and the Commitment to the Future of Medicare Act, CFMA.

The PHA definition includes the quality of the management and administration of the hospitals; the proper management of the health care system in general; the availability of financial resources for the management of the health care system and for the delivery of health care services; the accessibility to health services in the community where the hospital is located; and the quality of the care and treatment of patients. After all, that's what this is all about.

I'm almost done. The CFMA definition includes clear roles and responsibilities regarding the proper management of the health care system. The details of that are included in here. A clear definition within the bill would help to ensure due consideration to patient and community health care needs.

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In conclusion, we would like to reiterate our support for the aims and principles of Bill 36. We believe that LHINs have the potential to improve the integration and

delivery of health care services while meeting the unique needs and priorities of the communities they serve, if the legislation includes:

- population-based funding for both LHINs and their member hospitals;
- funding mechanisms to recognize the provision of services to patients from other LHINs;
- clearly articulated selection criteria for board members;
- clearly articulated criteria for integration decisions and an appropriate appeal mechanism;
- an amendment to preserve the independence of hospital foundations;
- a clear definition of the public interest.

We appreciate the opportunity to be here. We believe that Bill 36 recognizes the value of local hospital governance and builds on the strength and experience of local health care providers. We offer our recommendations to help ensure that this made-in-Ontario model of health care fulfils its promise. We look forward to working with you in that regard. Thank you very much.

The Chair: Thank you very much for your presentation. There is no time for questions, but thank you.

An address from the public announcement system was heard.

The Chair: This should be the last announcement. I understand that a contractor cut the wires, but there are some trucks outside and they should be fixing it. So maybe we won't have to hear that again.

The Clerk of the Committee: We may. Every 15 minutes, they have to, until it is fixed.

The Chair: Okay. So until it's fixed, every 15 minutes we're going to hear an announcement.

BRAMPTON HEALTH COALITION

The Chair: Having said that, we can move on to the next presentation, from the Brampton Health Coalition. Again, our apologies to those of you who are having difficulty properly listening to what the presenters are saying.

Mr. Ed Schmeler: Good afternoon, Mr. Chairman. Thank you to the standing committee on social policy for hearing our presentation. We're Ed Schmeler and Dora Jeffries from the Brampton Health Coalition. As members of a local health policy advocacy group, the Brampton Health Coalition, the authors of this presentation took part in the public consultations related to the Central West Local Health Integration Network. We attended the initial central west community LHIN workshop held in Orangeville in November 2004 and worked on the development of integration priorities for the Central West LHIN. Our initiative on transparency, community involvement and the creation of a LHIN community advisory group was developed in a team with six other participants at the workshop and was chosen by a vote of all workshop participants as one of the top 10 integration priorities of the Central West LHIN.

The authors were also members of the Central West LHIN steering committee, which worked with the staff of the Halton-Peel District Health Council and consulted with the local community members and organizations to complete the summary report of the Central West LHIN and submit it to the Ontario Ministry of Health on February 14, 2005. Again, on December 16, 2005, the steering committee met with the staff, board and CEO of the Central West LHIN and briefed them on updates to the priorities contained in the summary report.

The question is, what is the rationale for community involvement and transparency in LHIN operation? The LHIN vision, as outlined in LHIN bulletin number 1, states that it "engages communities in health system transformation." As participants in the creation of the Central West LHIN summary report, we met and interacted with many dedicated, passionate and hard-working members of the health services community. What struck us, however, was that there was very little participation and input in the process from front-line health workers and those most affected: the users of the system, the people of the community. It seemed to us that there was a need for transparency in the operation of LHINs and a mandate for community input and participation in LHIN decisions. This does not appear to be present in the proposed Bill 36.

What is it that we're proposing? First, legislated provision of a community advisory group, or CAG—one per LHIN. The CAG would consist of representative community members who would provide input to the LHIN board.

Second, we want to see legislated requirements for the provision of transparency in LHIN operations and decisions.

What's the rationale for transparency and for community advisory groups? Transparency in LHIN operations and the provision of community advisory groups would serve to integrate the grassroots needs of our communities and individual service providers on an ongoing basis. The engagement of the public by LHIN boards in their planning, priority setting and budgetary activities would help us ensure that board decisions reflect community health needs and priorities. If the introduction of LHINs into the provincial health system is proposed as a transformation that will improve citizens' lives and health, then health care workers, clients, patients and families must be part of the proposed partnership of equals.

There are legislative precedents in Ontario for health care community advisory groups; they already exist. The first one is the Toronto Board of Health—local health committees, or LHCs. In early 2002, the Toronto Board of Health mandated the creation of local health committees to assist the board of health in determining and setting public health policy on a broad range of local health issues and to raise health determinant awareness and its impact on Toronto communities. The terms of reference covered mandate, roles and responsibilities, composition, term of office, remuneration, meetings,

quorum and committee member qualifications. The medical officer of health for Toronto at that time was Dr. Sheela Basrur, who is now Ontario's chief medical officer of health and assistant deputy minister of health.

The second act is the Accessibility for Ontarians with Disabilities Act—the accessibility advisory committees that are set up under that act. The act requires municipal councils to prepare an annual accessibility plan and either seek advice from the AAC it establishes or consult with persons with disabilities and others on the identification and elimination of accessibility barriers to persons with disabilities.

The third existing legislation is the Community Care Access Corporations Act—the community advisory councils. In respect to the boards of directors of community care access corporations, the act mandates, “Each board of directors shall establish a community advisory council as a committee of the board.”

What legislative precedents are there for transparency? Let's look at the Municipal Act, 2001. The Municipal Act provides that, with only certain specific legislated exceptions, all meetings shall be open to the public, and records and minutes, subject to the same exceptions, must be made available to the public. Furthermore, before holding a meeting or part of a meeting that is to be closed to the public, a municipality or local board or a committee of either must state by resolution the fact of holding the closed meeting and the general nature of the matter to be considered at the closed meeting.

We developed this information as part of community consultations. What did we learn? The first thing we learned was that in order for LHINs to succeed in achieving their stated vision of community engagement, they must practise openness and transparency and hold open board meetings. Community consultation works; the research on methods and benefits has already been done. Third, it's not necessary to reinvent the wheel to provide openness, transparency and public input in LHLN operations. Provincial and municipal legislative precedents that can be adopted already exist.

Finally, I'd like to say that there's a reference study on community consultation, *Towards More Meaningful, Informed, and Effective Public Consultation*. We've provided an electronic copy to Ms. Stokes, clerk of the standing committee, and she can make it available to any members of the committee or to the research people who would like to see it.

Now I would like to pass it over to Dora Jeffries. She'll be speaking on the second part, which is on LHINs and privatization.

Ms. Dora Jeffries: As members of a local health policy advocacy group, the Brampton Health Coalition, the authors of this presentation have been opposing the P3, public-private partnership, financing model of the new Brampton hospital since it was arbitrarily introduced to our community in 2001 by former health minister Tony Clement. We continue to oppose this funding model, which has introduced a level of privatization previously not a part of Ontario's health care system. Our

group, as part of the Ontario Health Coalition, has been involved in a court case for three years now to force full disclosure of the details of the secret Brampton P3 hospital deal. We do know that the present value of the difference between public and private financing is \$175 million. In Brampton we know, from our experience and the well-documented experiences in the United Kingdom, that more privatization is not a better or cheaper way to deliver quality health care. Therefore, we are alarmed by the opportunities for increased privatization in Bill 36.

1400

The minister may, under Bill 36, order any non-profit health service provider that receives funding from a LHIN to close down; this does not apply to for-profits. The minister may amalgamate non-profit health service providers; they cannot amalgamate for-profits. The minister may transfer all of the operations of any non-profit health service providers to other non-profits; this does not apply to for-profits. The minister may transfer property of non-profits or any other actions necessary to carry out these things; this does not apply to for-profits. These are in part V, sections 28 and 29 of the bill.

Privatization: The legislation facilitates privatization in several ways. The LHINs may move funding, services, employees and some property from non-profits to for-profits. Cabinet may order the wholesale privatization or contracting out of all support services in hospitals. The minister may close or amalgamate non-profits, but not for-profits. With all of this power in place, it is not difficult to foresee a shrinking set of non-profit providers while for-profits grow and gain new market opportunities as the system is restructured. This is in part V, sections 28 and 29.

To conclude, the residents of Brampton have been part of an experiment in increasing the for-profit involvement in our health care system through our P3 hospital. This hospital was introduced into our community with no public consultation or proof that this financial model would be beneficial to the taxpayers. Because of our experience, we are extremely sensitive to the alienation caused in a community when public consultation is ignored. We are also acutely aware of the increased costs and loss of control, loss of transparency and accountability when a private for-profit consortium can enter into secret deals with our government.

The Chair: We have about three minutes available, one minute each. We'll start with Mrs. Witmer, please.

Mrs. Witmer: Thank you very much. You indicated here that the difference between public and private financing is this \$175 million. Was that for the Brampton project?

Ms. Jeffries: Exactly. That's in present dollars. If you put that over the 25-year life of the contract, it's actually more. That is just the slightly over 1% difference in borrowing from the public sector, and then handing it over to the private sector and having them go out and raise the money. That's the private financing model that is prevalent in the United Kingdom, which is costing so much money and which is costing us more. That is only a

small part of the deal that we know. We are in court to find out what other costs are there in the deal. We still don't know.

Mrs. Witmer: I was going to say that my belief was that that information had not been made publicly available. It's pretty well still in the dark.

Ms. Jeffries: Most of the deal is.

Mrs. Witmer: Yes.

Ms. Jeffries: This information, this borrowing cost differential, is available, but as you are saying, most of the financial information is still secret.

The Chair: Ms. Martel, please.

Ms. Martel: Earlier this morning you weren't here, but the minister made some comments about the bill. He said that there were a number of critics who were making baseless attacks and spreading deliberate misinformation about the bill. In his response, he said he disagreed that LHINs are going to open the door to privatization and two-tier health. I'm glad that one of the focuses of your presentation had to do with privatization and the sections in the bill that allow for that.

Outside of the sections in the bill where that's clearly articulated—this may sound like a silly question—what is the concern that you have as an individual taxpayer, but also as a coalition, about increased privatization in terms of where money goes when it should be going to patient care?

Ms. Jeffries: As I said, the secrecy of the deal alarms us, and we feel that the competitive bidding model used for home care and the creation of internal competitive markets, which is the British system, which seems to be what this is modelled on, will increase privatization, which actually costs more. In the United Kingdom, they're about 10 years ahead of us in this kind of model, and there is ample proof that this system costs more. In fact, the Economist is even calling for a moratorium on the increased privatization in the British system, the PFI—Private Financial Initiatives. So it really worries us to see all the opportunities in this bill for increased privatization.

The Chair: Thank you. Mr. Fonseca.

Mr. Fonseca: Thank you very much for your presentation. As the minister brought forward this legislation, and being patient-centred, he was looking at the 12 million people in Ontario and to really address the regional inequities that happened for so long, especially addressing high-growth-needs communities like Brampton and the Central West LHIN. So what the LHIN legislation actually does, and allows the ministry to do, is to address those needs. In a previous presentation, we saw in their graph that the Central West LHIN does have many needs that have not been addressed: This will help address those needs.

In regard to the LHIN boards and in terms of the local community, the LHINs are actually required to establish a process to identify candidates from that community who will make up a portion of that board. That is in play right now through the LHIN executives who are coming up with those criteria to address some of your needs. Do

you think it would be a good process to be bringing in the local knowledge and skilled people who will help in terms of being at the table for that community?

Ms. Jeffries: As we said in our presentation, we don't think it's sufficient; we do not think it's enough.

Mr. Fonseca: Okay. But it is moving in a way that you would like to see it move.

Ms. Jeffries: When we read the legislation, we do not see the power going to the community. It seems to me that it's very centralized, that this is a centralization of power in order to restructure the health care system and make decisions that are not going to be popular.

The Chair: Thank you very much for your presentation.

FRIENDS OF AJAX/PICKERING HOSPITAL

The Chair: We'll go to the next presentation, the Friends of Ajax/Pickering Hospital. Good afternoon. You can start any time you are ready, please.

Mr. Fred Parrott: Chair and members of the committee, on behalf of the Friends of Ajax/Pickering Hospital, my colleague Bill Parrish and myself, Fred Parrott, thank you for this chance.

First, we'd just like to recognize two other members of our Friends: Peter Mawby and Lynne Childerhouse, who did the spadework in this presentation. We'd like them to get credit for that.

The Friends of Ajax/Pickering Hospital is a volunteer patient advocacy group concerned with health care issues affecting the communities of Ajax, Pickering, Whitby and west Durham. The main focus of the group has been the erosion of services from the Ajax and Pickering hospital since the amalgamation in 1998 with Scarborough Centenary Hospital to form the Rouge Valley Health System. Recent public forums organized by the friends have attracted over 1,700 people, providing invaluable opportunities for community input. Two of our members attended the first central east LHIN workshop in December, 2004.

Here are our concerns: (1) The key word, "integration," is in fact very misleading regarding many of the potential activities suggested by this legislation. "Integrate" is defined in the act as:

—"to coordinate services and interactions...,"

—"to partner with another person or entity" to provide services;

—"to transfer, merge or amalgamate services, operations, persons or entities,

—"to start or cease providing services,

—"to cease to operate or dissolve or wind up the operations of a person or entity."

The English language takes exception to that definition since there's a second word, "disintegrate," to define the actions of the last three: "cease," "dissolve" and "wind up." When disintegration begins to occur, the electorate will react and could feel misled by the emphasis on integration. We have seen strong evidence in our community of this sort of reaction.

(2) Provision in Bill 36 for community, as in public, input on health issues such as mergers, amalgamations and integration and disintegration of services etc. is non-existent. As specified in the act, the engagement of “the community of persons and entities” on topics including integrated health service plans and setting priorities means the engagement of the people within the relevant health service area. The public is not part of this process.

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The Minister of Health shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions. The bill does not provide for any public input into this plan. No public appeal process is provided.

The LHIN boards should be prime sources—

Feedback from the public announcement system was heard.

Mr. Parrott: The LHIN boards should be prime sources of communication with the public.

Feedback from the public announcement system was heard.

The Chair: You can proceed.

Mr. Parrott: Those LHIN boards—prime sources of communication potential. However, cabinet will decide by regulation which LHIN meetings will be public, with no requirement for a public process of consultation. A minimum of four board meetings is required in a calendar year, which is a very pitiful number, given the scope of their responsibilities. These and committee meetings are at the discretion of cabinet as to whether they should be open to the public.

Regarding integration—or disintegration—decisions, notice will be given to the health service providers of the decision, with copies to the public. Because of the geography of many LHINs, all decisions should be posted on a website for improved public access. The only appeal process is by health care providers party to the decision, and this is only after the decision is made. Public input is limited to the polling booth at the next election, which is far too late to have any positive impact on the health of people's lives.

(3) The development of the regulations will be handled as follows: The public is to be informed about the proposed regulations by notice in the Ontario Gazette and by other means the minister deems appropriate. The involvement of persons and entities who may be affected will be sought. However, here again public input is hardly encouraged, and even the health care providers will find that there are some circumstances where their input is not required.

(4) Through the processes of strategic plans and accountability agreements, the minister awards contracts to health service providers and implements them. No public input is required or public appeal process provided. Health service providers have the only appeal process of 30 days against the decisions of the LHINs.

Furthermore, the bill does not specify measurements of service levels, public satisfaction experiences or goals to be achieved other than those specified in the account-

ability agreements. Thus it is feared that the lowest-bidding health care provider, private or public, will win out most often.

(5) The LHIN boards and staff will assume control over most of the health care providers in Ontario. These boards of directors, duly appointed to their position, may pass any bylaws and resolutions for conducting and managing the affairs of the LHIN, including establishing committees. Where are the controls for the regulations they may determine necessary for the operation of the LHIN?

The LHIN will create an additional level of bureaucracy that will impact our health system. The LHIN boards are to “consist of no more than nine members”; 14 LHINs times nine is equal to a possible 126 paid positions. As well, each LHIN “shall appoint and employ a chief executive officer.” Now we have 140. Furthermore, the LHIN may employ other employees that the network considers necessary for the proper conduct of the business of the network. Even if this were to be only one other person per LHIN, we are now looking at additional salary costs, a further drain to our health care dollars, of 154 people.

(6) How can we achieve an integrated health system without including the major providers of primary health care?

At the outset, the legislation includes hospitals, certain psychiatric facilities, long-term-care facilities, home care, community mental health and addiction agencies, community health service providers, community health centres and others by regulation. It does not include family doctors, chiropractors, dentists, optometrists, independent health facilities, laboratories, public health and certain corporations of health professionals.

How can we achieve an integrated health system without including the major providers of primary health care? Leaving family doctors out of the LHINs is a serious mistake.

We therefore make the following recommendations: To achieve meaningful and extensive input from people governed by the LHINs, Bill 36 should be amended as follows:

(1) The provincial strategic plan for the provincial health system be published and widely circulated, with public input invited before the provincial strategic plan is adopted by the minister.

(2) Before any LHIN board makes any decision to integrate, merge, amalgamate, partner etc. any health service affecting any community, it must first publish the details of the plan with the rationale. The public must be given at least 90 days for comment and input before any final decision is made.

(3) Any decision of a LHIN that affects the health care of the people in a community must be subject to appeal. Any person or group should be able to appeal the decision of a LHIN with at least 60 days' time after the LHIN has published its decision to do so. First appeal goes to the LHIN board. If this is denied, then an appeal to the minister and then to the Ombudsman.

(4) All the details of how the people should be involved in the LHIN board decision-making must be spelled out in Bill 36 before it is passed and not left to regulations.

(5) Any order by the Minister of Health and Long-Term Care to order a hospital to cease operation or cease to offer services must include public notification and public hearings before any final decisions are made. This directive must also be subject to an appeal process, as mentioned earlier.

(6) All the reports being considered or studied by a LHIN board must be made available to the public on a website before the report is adopted.

(7) Minutes of LHIN board meetings must be made available to the public on a website or on request.

(8) Finally, if the Legislature and the government do not amend Bill 36 to provide for major public input and involvement at the LHIN board level, the people who pay 100% of the costs of their health care system will have lost all input and control. The minister will have achieved complete centralized power over our health care.

The LHINs may have been conceived with the greatest intent for our health system, bringing, as Minister Smitherman said previously, "capacity that's in the same place, closer to the action, in local communities, with people dedicated to their communities." In actuality, the health system is being redesigned, in our view, to provide the cheapest health care services without regard for where the patients and their families live, as well as creating another level of bureaucracy at the expense of our health care system. Thank you very much.

The Chair: Thank you very much for your presentation. We have run out of time, so there's no time for questions. But thank you for your presentation.

ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

The Chair: The next presentation is going to be the Ontario Association of Community Care Access Centres. As you come in, gentlemen, you have 15 minutes. Whenever you are ready, you can start. There is some disturbance, as you may have heard, so if that's the case, you may wish to proceed or stop, as you choose.

Mr. Ross McCrimmon: As long as you can hear us, we can continue.

The Chair: We are able to hear you, yes. So please start whenever.

Mr. McCrimmon: Good afternoon. I'm Ross McCrimmon. I'm the chair of the Ontario Association of Community Care Access Centres. I'm here with Jim Armstrong, our chief executive officer. It's a pleasure to have the opportunity to speak with you this afternoon.

The Ontario Association of Community Care Access Centres is a voluntary organization that represents Ontario's 42 CCACs. As the provincial voice for CCACs, our mission is to represent the interests of our members, to act as a vehicle for the development of common policy and shared services, to provide

leadership in shaping health care policy, and to promote best practices on behalf of the people served by their community care access centres.

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Each year, CCACs provide coordinated access to health and support services to approximately half a million clients. Through our case managers and care coordinators and our information and referral processes, CCACs play a significant role in promoting independent living, helping people to navigate the health care system and providing a bridge to other health care services.

Over the past two years, the government has made a significant investment in CCACs in recognition of the contribution of CCAC services to a broad health system transformation.

CCACs are working at the local and provincial level:

(1) To support the development of family health teams and build formal relationships with other primary care groups to promote service integration;

(2) To support hospital service plan development and implementation;

(3) To provide comprehensive and compassionate end-of-life care;

(4) To develop strategies to improve the management of chronic conditions; and

(5) With home care providers, to improve and simplify the service procurement process and to implement the other recommendations of Elinor Caplan's review, once approved by the minister.

Finally, over the last year, the OACCAC and our members have been engaged in ongoing discussions with the Ministry of Health and Long-Term Care regarding the proposed plan to align CCACs within the LHIN boundaries and consolidate CCACs within each LHIN.

Let me begin my comments on Bill 36 by stating our support for development of local health integration networks, for the principles underlying the Local Health System Integration Act and for the objects outlined for LHINs in section 5 of the bill.

We believe that the linkage of responsibility for community-based planning, funding and accountability provides great potential for the development of a system that fosters collaboration and innovative approaches to service integration and is responsive to local conditions.

We also believe that subsection 17(2), which creates the potential for LHINs to retain a portion of any savings generated through efficiencies to reinvest in services, is an important step forward. Historically, there have been few incentives for health care service providers who realize savings through efficiencies only to see that these savings are recovered and lost to service enhancements at year-end.

Section 16 addresses the responsibilities of the LHIN to engage the community in planning and priority setting. Further, clause 36(1)(f) provides for regulation-making authority regarding the nature of the engagement process. We support this approach, but we caution against including provisions in the act binding the LHINs to a specific process for engagement that may prove to be

inadequate or unworkable over time. As an example, the CCAC act included a specific requirement for CCAC boards to convene community advisory councils. In many communities, these councils were not an effective mechanism for community engagement, and this requirement is being removed through the complementary amendments in Bill 36.

We believe that any provisions setting out specific requirements or processes for community engagement would be better addressed in regulation, to more easily facilitate development and improvement of the process over time. We would, however, encourage broad consultation on any regulations dealing with the community engagement process.

Subsection 16(2) also sets out a specific responsibility for the LHIN to establish a health professions advisory committee consisting of representatives of the regulated health care professions. It is important to recognize that a significant portion of health care services are provided by unregulated health care workers, including personal support workers and volunteers. We would encourage recognition of their valuable contribution and input into the advisory process to the LHIN.

Subsection 20(2) deals with patient mobility and prohibits the LHIN from entering into agreements or arrangements that restrict access or prevent individuals from receiving services based on geography. Subsection 20(3) provides an exception for agreements between LHINs and CCACs, recognizing that CCACs provide services within an approved geographic area. We recognize the need for this exception, given that our services are primarily provided in our clients' homes, and have no problem with the clause. We do, however, want to identify that there are circumstances in which CCACs coordinate services to clients who live outside a CCAC's geographic boundaries. Two key examples include facilitating placement in long-term-care homes for clients who live outside a CCAC's geography and facilitating discharges from hospitals to home that cross geographic boundaries. It will be important to ensure that accountability agreements between the LHINs and the CCACs recognize these circumstances.

The remainder of our comments relate to the complementary amendments to the CCAC act under part VII of the bill and the proposal to amalgamate CCACs and align them with the LHIN boundaries.

Under the current provisions of the CCAC act, CCAC boards and executive directors are appointed through the Lieutenant Governor in Council. In addition, the minister is responsible for fixing the salary, benefits and other remuneration for the executive director. Our experience has been that this framework created dual, and often ambiguous, accountability relationships that diminished the board governance. This approach has also created a corresponding increase in the government's obligation in administering a massive appointment process. There has been a high degree of uncertainty and instability for CCAC board members and executive directors, with long delays for new appointments and with reappointments often occurring within days of the expiration of the term.

We are, therefore, very pleased with the proposed amendments that would return CCACs to the status of non-profit corporations under the Corporations Act, with the power to elect their board of directors, retain and set employment terms for chief executive officers and create bylaws to govern their structure and operations. These amendments are consistent with recommendations that we brought forward to the Ministry of Health and Long-Term Care following a motion ratified at the annual general meeting of our membership last June. We believe that these amendments will provide a framework for greater stability and clearer accountability in our sector.

As mentioned earlier, the OACCAC and our members have been engaged in extensive discussions with the Ministry of Health and Long-Term Care over the past year in relation to the proposal to amalgamate CCACs and align our boundaries with those of the LHINs. While not universal, there is a significant level of support among CCACs for consolidation and alignment. Concerns remain about the impact of creating larger, more complex organizations serving diverse populations and geography. Our members have identified the need to ensure equity in service distribution across regions; sensitivity to regional diversity, including local representation; and an adequate time frame for implementation. It will also be essential that the transition process ensures the fair and equitable treatment of staff affected by the proposed change, continuity in local partnerships and agreements with our service providers and, above all, stable services to our clients. However, our sector remains committed to working with the ministry to ensure a smooth and seamless transition that provides stability of client services, assuming the plan goes forward.

Finally, the Minister of Health and Long-Term Care, in his remarks to the Legislature, indicated that the government is considering a broader role for CCACs in the future. The power in the bill to make regulations contains provisions that would allow the Lieutenant Governor in Council to support an expansion of the CCAC role. We believe there is considerable potential to further build our care coordination, experience and resources through these partnerships with family physicians, hospitals and other community agencies to facilitate access, improve service integration and support clients as they navigate their way through the health system. This in no way diminishes the significant roles our health care partners play in providing access to services, nor should it impede or complicate people's ability to gain entry to the health service system through a variety of portals.

On behalf of the CCACs and our association, we are grateful for the opportunity to share our views on this important piece of health care legislation.

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The Chair: Thank you. There are three minutes; one minute each. Ms. Martel.

Ms. Martel: Thank you for being here today. Let me go to page 5, where you say you're pleased that the

government is bringing in proposed amendments to “return CCACs to the status of non-profit corporations under the Corporations Act, with the power to elect their board of directors, retain and set employment terms for chief executive officers and create bylaws....” What would you say if some of those principles were actually applied to the LHINs?

Mr. McCrimmon: Jim, do you want respond?

Dr. James Armstrong: We haven’t been addressing that question in terms of the LHINs. We’ve only been focused on the access centres and what we see as desirable for the services.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. I want to go to your point about unregulated health professionals. You were talking, I think, about part III, subsection 16(2), where there’s a health professionals advisory committee. Is your suggestion that that committee should include unregulated health professionals, or are you suggesting that there should be another advisory committee of unregulated health professionals?

Mr. McCrimmon: Either way, but we do think there should be some method whereby they have the opportunity to input to the LHIN organization.

Ms. Wynne: Okay. It’s a very interesting point. Thank you very much.

The Chair: Mrs. Witmer.

Mrs. Witmer: I was going to ask the same question as Ms. Martel. However, I guess what you see in all of this is that the minister has made some commitment to expanding the role of CCACs in the future. That may well take place at the expense of the hospitals. Have you considered that probability? The minister’s chief of staff said the other day at a conference I was at that hospitals don’t speak to community needs. Do you see your organization, then, assuming some of the responsibilities?

Mr. McCrimmon: I think we’re basically looking at other expansion, whereby our case managers can perhaps provide a service to other ministries.

The Chair: Thank you for your presentation, gentlemen.

ONTARIO HEALTH COALITION

The Chair: The next presentation is from the Ontario Health Coalition. Good afternoon.

Ms. Natalie Mehra: Good afternoon.

An emergency alarm sounded.

Ms. Mehra: Okay?

The Chair: Any time you’re ready.

Ms. Mehra: Okay, great. I was sitting here thinking that Jean-Paul Sartre wrote a play about how hell is a meeting in a very hot room that never ends. Even he didn’t think of adding a fire alarm. I do thank you, and I’m sure it’s been just an insufferable day for you here.

I would like to start with some comments about the response of our members across Ontario to the introduction of this legislation. As you know very well, the province isn’t a blank slate when it comes to health

restructuring. We have actually been through significant health restructuring over the last decade or decade and a half, or longer. That experience, I think, colours many people’s approach to new legislation to provide powers to restructure the health system. A lot of our concerns flow from the experience of health restructuring over the last several years.

Like the hospital restructuring legislation brought in by the Conservatives, this bill increases government powers over health providers in order to facilitate restructuring. Like the Conservatives’ restructuring, there are few checks and balances to ensure that the process can’t go awry, and where there are, they’re inadequate. We believe that the lessons learned by community members, health care providers and staff in the last round of restructuring are very important to take into consideration when looking at this new piece of legislation.

Certainly, it appears in this legislation that a lot of thought has gone into how the power system will work: how the minister will achieve his powers, how the transfers of property will take place and how the mergers and amalgamations will take place. But it appears that less thought has gone into what checks and balances will be in place on that power and how the public will interact with the directions of the health ministry, and in fact, how the health minister’s ideas about the health system interact with the civic-minded individuals who have spent the last several generations in their communities raising money to build local community hospitals and to improve local access to comprehensive health care services.

In this legislation, a full system of centralized power or centralized planning, sometimes referred to as a kind of command-and-control structure, has been set up. But any kind of central command structure for any public service, as we’ve learned from history, requires democratic input. It requires proactive seeking of democratic input. It requires a feedback loop. It requires checks and balances. It requires clarity of principles and direction of restructuring.

In the last round of restructuring, if I can refresh your memory—there is no official evaluation of it, but what happened, ultimately, was that 9,000 critical, acute and chronic care hospital beds across the province were ordered closed and 26,000 full-time-equivalent hospital worker positions were laid off. The care that was moved out of hospitals into the community and the new capacity that was built in the community in long-term-care facilities and in home care were overwhelmingly privatized and remain that way to this day. The incredibly expensive hospital building program that was ordered by the restructuring commission was privatized through P3s and continues to be privatized to this day. The balance of not-for-profit and public delivery of health care, compared to for-profit, private delivery of health care, was changed, possibly forever, in the health system.

At the end of the day, important hospital services—like physiotherapy, rehabilitation, chiropractic, other types of hospital services—were cut from hospitals and have

never been replaced in the public health care system. You can't get them for free, and certainly not in a timely fashion, in many communities across the province.

At the end of the last round of hospital restructuring, what we learned was:

- that restructuring geared to cutting costs or to finding budget efficiencies simply leads to offloading;

- that the facilities off-load services and they're not picked up anywhere. You don't need to delist things from OHIP; they're just cut, and they never return;

- that restructuring done badly can drastically increase costs without improving the health system. In fact, the costs in the last round of restructuring, according to the provincial auditor, escalated \$2.8 billion over projected amounts;

- that restructuring can create vast new market opportunities for the for-profit health industry;

- that the destabilization brought about by restructuring can take years, and millions of dollars, to undo.

We believe that the principles that guide any restructuring in the health system must be more specific and more protective of the public interest than simply including the term "public interest"; that the principles of the Canada Health Act must be incorporated into Ontario legislation regarding restructuring; that meeting population need and moving comprehensive health care services as close to home as possible—these types of principles—must be front and centre; and there must be democratic checks and balances.

We find that the unequal treatment of the for- and non-profits in the legislation is indefensible. We note in the legislation that the LHINs already have the power to transfer funding and services out of not-for-profits into other not-for profits and into for-profits or into third-party, contracted-out agencies, whatever they may be. Why, then, does the minister need the additional powers to order the closures of non-profit agencies? Why would this legislation set up a dichotomy in which the property and services of not-for-profits, which have been built by local communities and people who are civically engaged out of the goodness of their hearts and out of the concern for their communities, are treated with less respect than property and services that are run for the purpose of seeking profit?

Furthermore, while this government obviously trusts itself with the increased powers that it gives itself in this legislation, would this government trust another potential future government with the powers in this legislation? For instance, if the Conservative were to win the next election, would you support the minister having the unilateral power to order the closure of the not-for-profits in the health system, to order the mergers and amalgamations of the not-for-profits etc.?

1440

In terms of democracy, as we say, this is really the set-up of an extended central planning system, but without a kind of glasnost, without a kind of openness in the health system. You should know that many health care workers are covered by gag orders and not allowed to speak out

about poor practices in their facilities or in their particular health sector. The LHINs boards that are appointed by cabinet and can be replaced at cabinet's will etc. are clearly centrally controlled, and cabinet is given the inexplicable power to exclude "any persons or classes of persons" from LHINs membership, which seems to be a set-up for discrimination. There are no protections in the legislation to prevent a revolving door, for instance, between the for-profit health industry and the LHINs boards, and we have deep concerns about that.

We're concerned about why the democratic protections in this legislation are so different than those in other provincially set regional governance structures; for example, municipalities and school boards, both of which are creatures of the province, both of which have much stronger protections against in camera meetings, both of which have the right for public deputations, for public submissions, for public appeals, all kinds of procedural protections in their legislation. Why is it, then, that the health system's restructuring legislation is so inadequate in comparison? I will append to our submission the sections of the Municipal Act and the Education Act that limit in camera meetings and call for democratic processes.

In terms of privatization, I think you've heard from other groups that we're extremely concerned about the powers to close the not-for-profits and not the for-profits. We're also concerned about the part of the legislation that gives cabinet the power to order the contracting out of all support services in hospitals. We clearly object to that.

I've heard that in the minister's comments he raised questions about the concerns about competitive bidding in the health system. I don't think this is a problem of interpretation. In fact, competitive bidding has already been introduced in the hospital system through the wait time strategy for cataract surgeries. Hospitals are bidding on a price basis, and those hospitals that meet or come below the ministry's target on a price basis for those services will get those services. This has already been announced. It's on the record. There is no question about whether or not that is happening; it is happening. In addition, the ministry is on the record as being supportive of the findings of Elinor Caplan's review supporting the continuation of competitive bidding on home care. So we have good, concrete reasons to be concerned about the extension of competitive bidding, which we believe has been extremely damaging to the health system and which also, I believe, puts your government at odds with all of the civic-minded people who have been trying to build local access to community health services.

I should also note that in no jurisdiction the size of Ontario has either the attempt to specialize hospitals in this way or the competitive bidding system been tried. It has been tried in Catalonia, as I understand, which is a small area of Spain. It has been tried in Britain. Well, you can fit Britain four times into the province of Ontario. The Northwest LHIN can fit the entire geography of Spain, Portugal and France into it. It costs \$700 to fly

from Kenora to Thunder Bay. There is no train. It's a six-hour drive, as some of you will know.

So the kinds of geography and population demographics that we're talking about really preclude specialization in hospitals in this province, and we urge you to look extremely carefully at the strategic direction of the ministry regarding competitive bidding.

I'll conclude with the labour issues. This legislation includes a significant portion on labour issues. I can't talk extensively about it, but we are deeply concerned about the different treatment that doctors, for instance, in the health system are getting in order to buy their support for transformation of the health system versus the women, for example, who work in hospitals in the support services. The ability for the government to order the wholesale contracting out and potential privatization of their jobs is offensive to all of us, and we hope that you'll take that out. Thank you.

The Chair: Thank you very much for your presentation. You used all of the 15 minutes, so thank you again.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 311

The Chair: The next presentation is from the Ontario Public Service Employees Union, local 366. Good afternoon.

Ms. Connie Ferrara: Good afternoon. It's 311 now.

The Chair: Okay. Thank you. Please proceed any time.

Ms. Ferrara: Hello. My name is Connie Ferrara. I'm a pharmacy technician employed at the Rouge Valley Health Centre in Ajax. I have been a pharmacy technician for almost 36 years. I know my job and I do it well. This is because if I'm not doing my job well, it could have serious repercussions.

Throughout Canada, there is a shortage of pharmacists. Technicians now perform a vital role, and more and more tasks are delegated to us because of the shortage. Downloading the pharmacy services to the community would put patients at risk.

Community pharmacies employ technicians who do not have the same scope of practice that hospital technicians have. For example, in the community, the technician counts the pills or pours the liquid medication from one bottle to another under the supervision of the pharmacist. Sometimes, and a lot of the times, the front-store cashier is called to help count the meds or pour the liquids when the pharmacist and pharmacy staff are very busy.

In hospital, the technician screens the doctor's orders, we look for incompatibilities such as drug allergies, heights and weights of patients, and we also do order entry for certain medications. Technicians check orders after they are filled and before they are delivered to the nurse's station. We prepare IV medications, chemo and compound special orders. We dispense narcotics and maintain files. Technicians provide a responsible quality

of service that community technicians are not trained to do.

If pharmacy services were downloaded to community pharmacies where pharmacist shortages are prevalent, who would fill these orders—the front-shop cashier or the cosmetician? If the cosmetician gets the order wrong, maybe she can offer her other services to the funeral parlour.

But kidding aside, each and every hospital needs an in-patient pharmacy. We have stat orders on a constant, daily basis. Medications are delivered to the emergency department, to the ICU and to the OR within minutes in a serious situation; off-site services would cost lives. Health care is something we take for granted. That is because it has been available to us and we don't miss something until we lose it. Health is very precious; this you find out the hard way.

Years ago, I had a very ill child. He faced a life-threatening disease that devastated our whole family. Initially, he was in Sick Kids Hospital, where, after two weeks' stay, I was presented with a hospital bill totalling \$93,000. It clearly stated that if I did not have OHIP, I was responsible for payment. Luckily I did, and at that time to help my child, I would have done anything. His treatment took a long three years.

Three years ago, I had a minor stroke, and now I have developed diabetes. I am at the point in my life where health care is essential. I too took it for granted for a long time, but when you reach a certain age, you have worked for so many years, you have paid your taxes and you are expecting to eventually retire and enjoy life, guess what? You find that your health isn't what it used to be. What I do expect is that health care will be there for me, that the people elected will ensure that this service is protected, that a private company has not decimated the system for profit.

We all have aging relatives who require health care in one form or another. How is the community going to provide for them? What would your reaction be to your parent or grandparent having to travel to a distant city for treatment? What if their pension isn't enough for the expenses they would incur? Personally, for my family and me, this type of expense would wipe me out financially. I have worked since my teens, not only one job but, at times, three. I have raised four children on my own since my husband became disabled after a fall from a second-storey roof. I would need to sell my house to pay for expenses that I would incur if we needed to travel.

When I hear a candidate running for office promising to cut taxes, I tune that person out. Cutting taxes is not the answer; ensuring that our taxes are used appropriately is. The government should be ensuring that those tax dollars are used for services, not setting up LHINs without the proper consultations. You need to include us; you need to slow this process down and ensure that each and every step taken is the right one. We are the caregivers; we have the answers for you.

People are not stupid. We have past examples that are not easily forgotten. I personally hate the fact that my tax

dollars helped build the 407, only to have it sold to a private company which has raised the price for its use so that I can't afford to use it. The LHINs won't be forgotten or forgiven either if you don't put people first.

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The last government's cuts to hospitals left us hurting. Budget cuts have deteriorated services. One example in my hospital is that after amalgamation between Centenary and Ajax, dietary services were cut. The cafeteria hours in Ajax were cut when they opened a Tim Hortons in the building. Next, the CUPE members lost their jobs as the Tim Hortons employees now also run the cafeteria and prepare the patients' trays.

I can still see what Ajax hospital looked like 15 years ago and the state it is in now. Did we not learn anything from SARS? Did we quickly forget the price we paid for SARS and lies? Health care workers died. They did their jobs. How will the community serve in a pandemic? We know that that time will come. How will you defend your decisions then?

In my community of Ajax, when there was an immediate threat of closing pediatrics and maternal newborn services, the municipalities threatened to withhold funds to the hospital. These are tax dollars that people expect to be used for their needs, not for private companies looking to make a profit. If a publicly held hospital cannot meet their needs with their current budget, how would a for-profit company run it? The answer is obvious: Cut services and replace qualified staff with unqualified workers. Would you allow your child to be treated by unqualified staff? There is no way to guarantee that if a service is located at one site across the region, the patients from other areas will have timely access. For instance, Lakeridge Health has rehab and palliative care beds that first go to patients from their sites, shutting out Durham residents at the Ajax site. At Ajax, we have not had a patient admitted into one of these beds for years. The senior management at Rouge Valley does not consult with staff as to program needs and direction. They are out of touch with what is happening at the ward level. They have misinformation which they will be passing on to the LHIN, because paternalistic father knows best, and children—the staff—should be seen and not heard.

Senior management eliminated discharge planners at Rouge Valley and gave this work to social workers in order to save money. Social workers are now hard pressed to meet the social and emotional needs of patients and families when trying to explain why a family member has to be transferred to Scarborough for treatment. Now patients may need to travel even further abroad. There is no real concern for the emotional needs of patients and families at present, although the hospital mottoes are "We care" and "Family-centred care."

Also at present, senior management is unable to manage more surgeries being performed than beds available to accommodate at the Ajax site. Current practice is to scramble internally to find a bed. If a post-surgery service is no longer available internally, a patient will

have to be placed on a waiting list at another site, blocking beds. Presently at Rouge Valley mental health, we have a three-month day treatment group therapy; a three-week day hospital—support after being in hospital and to prevent hospitalization; a crisis service for the emergency room, not 24 hours and not on weekends; and in-patient treatment for the severely and persistently mentally ill. All of the above programs will be cut except for the day hospital and crisis service. The impact will be that the people normally attending these groups would have to find the equivalent in the community.

In the 1970s, the Ontario government began closing psychiatric hospitals, stating that patients will be cared for by services in the community. The community services did not exist. Scarce community services currently exist to meet social and emotional needs of patients. For children and adolescents in Ajax to see a child psychiatrist, they need to go to Lakeridge Health in Oshawa or the Centenary Shoniker Clinic. Our biggest concern is that if we combine services, what would stay and what would go?

I won't go into other examples. I'm sure that you will have heard and will hear a lot more than I could go into. I just want to leave you with a thought that this is a very serious process that you must decide. You need to remember that your constituents afforded you their faith and trust to act on their behalf and make decisions that allow them a certain quality of life. Rushing in this legislation without consultations and input from all of us will have serious repercussions.

Thank you for the opportunity to speak.

The Chair: Thank you very much for your presentation. We have about two minutes each. We'll start with Ms. Wynne, please.

Ms. Wynne: Thank you very much for coming here today. I have a couple of questions. First of all, you talked about the need for input. I guess one of my basic questions is, wouldn't a LHIN—a community-based organization, more local certainly than the ministry—be more accessible to the public than the minister's office or the ministry? What's happening in this legislation is that powers and planning authority are really being devolved to the 14 LHIN offices. I'm just a little confused about the sense that the minister's office or the ministry is more accessible than the LHINs will be.

Ms. Ferrara: I attended two LHIN meetings and I think I'm more confused than you are. With every single question that was asked at those LHIN meetings it was, "We don't have the answers. We don't have that information." So I can't tell you what would be better. All I can tell you is that since there is no information, how do I know what's going to benefit myself, my community, my children and my hospital?

Ms. Wynne: I guess what we're trying to say is that with this legislation we're bringing more clarity than there was before the legislation was brought into place. We're saying there will be a provincial plan that is in the process of being produced now, there will be consultations on that provincial plan, and then it'll be up to

the LHINs to have a local plan that fits in with the provincial plan. That's where the interface between the community and the needs of the community happens.

The private-public discussion is a parallel one, but the need for a plan that will allow for sustainability over the long term—you talk about the future. That's what we're trying to get at: a plan that will allow for health care in the future.

Ms. Ferrara: But we need to see that plan. I have no idea what's in that plan.

Secondly, how can someone like our chairperson, who is from the northern part of our LHIN, hundreds of miles away, know what we experience, what our needs are without having input from us? I can't see us being part of this process.

Ms. Wynne: So that community engagement piece is very important, is what you're saying.

Ms. Ferrara: Before everything is in place.

The Chair: Mr. Arnott.

Mr. Arnott: The government talks about the need for a long-term health care plan that is sustainable. I think all of us in Ontario would agree that that's needed. But some of the points that you've raised today are very important ones in the sense of issues that I've seen over the years in health care. When the government is contemplating a major change in health care direction, they don't often enough consult with the front-line health care workers. This is something we see time and time again. So your input has been very helpful in that respect.

Would you agree that Bill 36 is yet another example of where the government has not consulted adequately with front-line health care workers prior to its implementation?

Ms. Ferrara: Yes. I feel that perhaps, rather than starting up a new LHIN, we should have just expanded the services of our district health councils and maybe go back to the basis of why they were formed to begin with. The amalgamations were supposed to cut costs. Instead, we ended up with several tiers of a management system that just took away funds from where they should have been put.

The Chair: Ms. Martel.

Ms. Martel: Thank you for coming here today. I'm always interested when I hear the government say that this bill is all about powers and planning being devolved to the community. I hope the government members will read two legal opinions—one that's been put out by Sack Goldblatt Mitchell and the other by Cassels Brock—that just list page after page, section after section, how LHINs are controlled by the government, the erosion of local control, then the direct ministerial and cabinet control over local health service providers in a manner that is now unprecedented, even more than when the former government, for example, brought in the Health Services Restructuring Commission, or Bill 26.

There's nothing here about local control. The LHIN board members, for goodness' sake, are themselves appointed by government. They serve at the behest of government. They are agents of the government. They

can't even claim to be representative of the community because they're not even elected by the community, and they don't serve at the request or the behest of the community. So I find it a little hard to hear again and again how this is all about devolving local power.

The other interesting thing to me is that the LHINs are mandated to put in place this plan that the government has for health care across the province. We haven't seen the plan, we don't know who's involved in the consultation and we don't know where that's at. So the whole process really is about more central control. Health care is a function of how much money there is for the system, and the minister and the government make those decisions. Who gets health care, when and in what timely fashion is a function under the control of policies of the government with respect to who's going to get those services, where they're going to be located etc. The LHINs are going to do nothing about that. They have no power, no control and no say over any of those services.

If you'd like to say anything else, you go ahead. That's my speech for the day.

Ms. Ferrara: Well, that's just it. I'm totally confused.

The Chair: Thank you for your presentation.

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WELLESLEY CENTRAL HEALTH CORP.

The Chair: The next presentation is from Wellesley Central Health Corp., Dr. Bob Gardner and company. You may want to introduce your friend, please. Good afternoon.

Mr. Richard Blickstead: Good afternoon. Thank you, Mr. Chair. I'm Richard Blickstead. I'm the CEO of Wellesley Central. Wellesley Central, as you may know, is the successor organization to Wellesley Central Hospital. We are an organization that deals in research, capacity-building and public policy, as well as the re-development of the Wellesley lands. We look at health promotion and urban health from the social determinants of health perspective, particularly in the world of housing, income distribution and social exclusion. We've worked with the LHINs from their inception, and what we want to bring to your attention is that one size does not fit all, that there is a need for an ability of the LHINs to recognize that neighbourhoods are different, and that, having come to Wellesley from the private sector, we really need to listen to our customers more than we need to listen to our administrators. Bob Gardner, our director of public policy, will speak directly to that, and then we will be happy to answer any questions following.

Dr. Bob Gardner: In many ways, what we want to emphasize speaks to the question that Ms. Wynne raised: how community engagement will actually work. We want to talk about some possible amendments to the legislation and some incentives that could be built into the structure of Bill 36 that can allow for real community engagement.

We do think that LHINs have great potential. The idea of regional health planning and greater integration of

services and greater coordination has a real opportunity to create a much more seamless and equitable access to a full continuum of care on the ground. We agree with the principle and we agree that it's a very ambitious project. But the LHINs are only going to be able to succeed if they really do effectively reflect the diversity of the communities they work with. As you know, some of them are so huge and some of those communities are so diverse that that will be an incredible challenge. They'll only be able to work effectively if they develop priority-setting and resource allocation that really do reflect those community needs and really do result in a seamless continuum of care.

We want to talk a little bit about the mechanisms that would actually make that happen. We want to talk about some mechanisms that could allow the LHINs to foster innovation on the ground, and then to be able to share those successful pilot projects and experiments across the province. Really, our emphasis is that the LHINs legislation needs to be altered to ensure that the planning really is community-driven. One of the problems with health reform is that it has to look at the incentives and drivers that actually make health care work on the ground and in the institutions. So we're going to be making some concrete recommendations on the particular sections.

For example, we think that there need to be very clear expectations on all the LHINs to involve communities, very clear requirements that communities have to be involved in the planning and priority-setting. We think there are two key ways in which this can be done. One of them is to get much more specific about requirements for community participation in planning and priority-setting in the actual legislation. So we're recommending that section 18 be amended so that specific requirements and indicators for community engagement are built into the accountability agreements between the ministry and every LHIN.

I talked earlier about incentives. We think that subsection 17(1) needs to be amended to require that specific lines or envelopes are put in the LHIN budgets to support community engagement. In fact, allocation of that money is tied to successful attainment of targets for community engagement.

We also think, as Mr. Blickstead was mentioning earlier, that there's a tremendous challenge in reflecting the huge diversity of needs within the LHINs. The LHINs are very, very large. They need to find a way of integrating the region-wide planning with much more locally based and more neighbourhood-based planning. So we're suggesting to amend subsection 16(1) to require that each LHIN create local neighbourhood or community advisory committees, that those committees become the planning forums in which neighbourhood and local priorities and discussions are set, and that then there are mechanisms to feed that up into region-wide planning.

I know that the ministry and members have looked at the experience of other provinces, and you will know that all the other provinces that have had over a decade of

experience with regionalization have created this kind of more local or neighbourhood-based advisory or planning committee. Again, back to the main point: One size won't fit all. Quite what form these committees would take really will vary region by region. The ministry has the delicate balancing act of making sure that requirements are built into the legislation so that every LHIN does set up these committees but then be quite flexible on how particular regions and neighbourhoods do decide to organize themselves.

The other thing we think is that there's a tremendous amount of strength in the health care system at the moment. When the LHIN initiative was just starting, the ministry did some research and found over 1,000 examples of existing service and coordinating networks. They really should be built upon. We suggest amending subsection 15(1) so that one component of the integrated health service plans that each LHIN will be producing is that they specify very concretely how they will be building upon all of the existing networks in their region. We think that one starting point they should all have is to actually do an inventory of what already exists in their regions.

We also think that innovation has to be a very explicit part of each LHIN's mandate. Again, there's the same sort of balance of building that in too, so amend section 18 to require that the accountability agreements actually have very concrete expectations that the LHINs will fund and encourage pilot projects and experiments all through their regions. Also, amend subsection 17(1), the funding formula, so that's there's money for that and that, in fact, getting that money is tied to meeting targets in incubating and encouraging successful experiments. The province and the ministry, of course, have a responsibility as well to create an infrastructure, both a technological and a working culture infrastructure, that is able to share the innovations that are developed in particular regions across the LHINs and that can scale them up when appropriate.

We would echo some of the colleagues you heard from earlier that one of the more important issues is the question of funding and competitive bidding and what kind of mix of providers will work best. There has certainly been considerable research from Britain, if the government is looking for that kind of split purchaser-provider model, that there are problems with higher administrative costs, fragmentation and quality concerns among the commercial providers. There has been some concern about the experience of CCACs here in Ontario.

Luckily, the LHINs aren't going to be funding services for some years anyway, so there's time to hold a significant public debate on what the best mix of funding and service options is. Perhaps that's a role for this committee. It's something that the ministry certainly should do. We think the province should in fact issue a report with its own analysis of the pros and cons of different funding models. If it concludes that the British or some other model will work here, then lay out exactly what the costs and benefits of it might be.

As Mr. Blickstead said earlier, the main focus of Wellesley Central is on the social determinants of health. There's a huge amount of evidence, which I'm sure you're all familiar with, that poverty and inequality and poor housing and inadequate childcare are crucial factors in ill health for far too many. What does that mean for the LHINs? Obviously, a particular LHIN is not going to be responsible for ending homelessness in the province or in the country, but they certainly can be responsible for working with homelessness activists and housing providers and advocates in their region to try and do effective partnerships arrangements and innovative local experiments that would actually build addressing housing into improving health care delivery. For example, here in Toronto, Street Health and other outfits: We actually fund their research to provide really good primary care and supportive health care to homeless people.

The LHINs certainly should be accountable for that. They should be accountable for building into their plans how the social determinants of health will be addressed. So again, amend subsection 15(1) and amend subsection 13(1) to include that kind of requirement in the LHIN legislation. We actually think that section 5 should be amended to include addressing the social determinants of health as part of one of the core principles of this bill.

We'd like to stop there. We hope there's some time for questions. This is part of a much broader project that Wellesley has been doing. We have a great deal of material on our website. Your caucus researchers and your legislative research can look at that. Thank you very much.

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The Chair: Thank you. We have four and a half minutes available, one and a half each, and I'll start with Mrs. Witmer, please.

Mrs. Witmer: Thank you very much for your presentation and your recommendations regarding these sections. I think what I heard was that one of your biggest concerns was the fact that the LHINs in Bill 36, as presently structured, were not community-driven in the way they should be to reflect the needs of local individuals and local communities. What do you think the priority for this government is in amending the bill in order to ensure that that community input is reflected in all decision-making?

Dr. Gardner: Well, one thing, this committee may decide that it needs more extensive hearings to hear from more people. I expect that you've been quite overwhelmed with response.

We have made some specific recommendations on various sections in the bill that should be amended. We argued in our larger paper—and we invite you to take a look at it—that each of the LHINs should build into its own planning cycle very concrete consultations and priority-setting exercises with its communities. We think that each LHIN, for example, should have a very large community conference with its local region right away. We know there have been delays in setting them up. There's a base that they can build that on already. We

were involved in the local integration priority-setting exercise for the Toronto Central LHIN back about a year and some months ago. Mr. Blickstead was actually the chair of that. So there is already a list of people who could be invited to come back and say, "Okay, the LHINs are just getting rolling. What are the main priorities? What are the issues?" Perhaps one of the main things there is, what are unresolved issues that providers and advocates are hearing in their communities that the LHINs have to address? I would say that those kinds of planning conferences have to become part of an annual routine cycle, and also the neighbourhood planning forums that we've talked about that build up towards the priority-setting, the budget-setting and the reports that the LHINs will be making to the minister.

Mr. Blickstead: I'd like to add just one thing, if I could, very briefly. Over a year ago we met as a group, and I recall we had to write our report very quickly, work through the Christmas holidays at that time. I estimated that the amount of input was roughly \$250,000 of time. That was so that the LHINs could get community involvement. You know, you can't even get a meeting with the LHINs right now. It's easier to get hold of the Pope than it is to get hold of the LHINs and to speak to the LHINs about community issues and about listening to your customer. I think, unless you put that into the legislation, you will be in a very difficult position in terms of listening to customers. It's very, very disappointing to see the speed of change. Perhaps I'm speaking out of turn, but I think it's important that unless you put this into the legislation, it won't work as well.

The Chair: Ms. Martel, please.

Ms. Martel: I don't think you're speaking out of turn. That was very interesting. You can tell us more about some of your conversations, too, if you want.

I'm going to focus on competitive bidding. I've been an opponent of competitive bidding for a long time. I think it has been a total disaster in home care. Earlier this morning the minister, when he was talking about what opponents and critics would come to say and what kind of deliberate misinformation they were going to spread—those are his words, not mine—said that competitive bidding doesn't appear anywhere in the bill, so we should assume from that that competitive bidding is not going to be the way that LHINs purchase their goods and services. I'm assuming that you folks have read the legislation because you referenced a number of sections. It might not be in the bill; that doesn't mean it's not going to happen.

You also referenced some British examples, and it would be great if you would like to give us some titles so we can have some more research on this. I think this is exactly where we're going to end up because the government has done nothing to stop competitive bidding in home care, despite the upheaval in the system that we experienced under the Conservatives. I think that's exactly going to be the model. Maybe you can, with your references from Britain, give us some ideas about why that wouldn't be such a good idea.

Dr. Gardner: We're happy to send the available research to your research officer.

As you say, the bill is vague or permissive, depending upon one's perspective. But the danger there is, yes, we don't know exactly whether competitive bidding or what other combination of funding and service provider will drive it. That's why we would recommend that the government make that very clear and make it very clear right now. If it is going towards a particular model, be it the British or any other, then it presumably has done a great deal of internal research on the pros and cons and the relative cost benefits. We presume also that there has been a great deal of study of the history of the CCACs here in Ontario. There has been a great deal of program data for a number of years now. That data could be analyzed by the government and released. The work that the Honourable Elinor Caplan did reviewing the CCACs did not really go into any depth in the comparative quality or costs or consumer satisfaction with for-profit versus not-for-profit. Essentially, we would say that until the case is made, we would recommend that the government make it very clear that it will not be endorsing or allowing any for-profit provision until and unless it can make a strong case.

The Chair: Thank you.

Mr. Blickstead: I would just add to that, very briefly—I'm sorry—competitive bidding is not as much the problem as value. The issue is, the criterion has been price, not quality. So quality to the people of Ontario is what's important, not necessarily price.

The Chair: Thank you. Mr. Leal, please.

Mr. Jeff Leal (Peterborough): Through to Dr. Gardner, I'm just going to read a statement from Dr. David Naylor, who is the president of the University of Toronto and former dean of the faculty of medicine; I'll get you to comment on it.

Dr. Naylor said, "Community-based care reflects the needs of each community and is best planned, coordinated and funded in an integrated manner in that community. LHINs would engage their communities to involve Ontarians in a broad conversation and debate about their health care."

Can I just get you to comment on Dr. Naylor's statement? He's looked at this legislation; he's the leading expert in health care in the province of Ontario. I'd like to hear your comment on his observation.

Dr. Gardner: He has indeed, and he certainly is a leading expert. I think essentially he is saying what I opened with, that the LHINs have great potential, that if they do successfully engage our communities and do successfully integrate planning and service delivery, they really could make a difference to a seamless and an equitable continuum of care on the ground. But perhaps he didn't get, later in his statement, to some ifs and success factors. This is what we've been emphasizing: that the LHINs will be successful only if they do the kind of serious community planning that we have been outlining in our papers and if they do build in the kind of requirements and funding incentives that we have been talking about.

So I certainly don't disagree with Dr. Naylor. I would imagine he would say exactly the same thing. The whole history of academic and practitioner comment on regionalization in the other provinces is that it's a good idea that almost worked, but it needed to have a wider scope and more funding at times and it needed to engage its communities more seriously.

The Chair: Thank you.

Interjection.

Dr. Gardner: I'm not sure I exactly said that, sir.

The Chair: Thank you very much for your comments and answers. We just went a few minutes over the time, but thank you.

PETERBOROUGH HEALTH COALITION

The Chair: I will have the next presentation from the Peterborough Health Coalition, Mr. Roy Brady. You can start any time you're ready, Mr. Brady.

Mr. Roy Brady: I want to thank the entire committee for giving me an opportunity to come here this afternoon. I think I have something to get you thinking. My name is Roy Brady. I'm the chair of a citizens' watchdog group in Peterborough and it's a chapter of the Ontario Health Coalition, which has very acute concerns regarding the local health care scene, as well as the provincial and federal levels.

I'm going to provide some general analysis of problems I see with Bill 36. This should lead to some serious amendments on your part. Secondly, I want to get into the Peterborough health care situation, because I feel that the lack of influence locally has retarded health care improvement.

The text you have in front of you would be about 90% of what I have to say.

Statements from political officials and health care administrators have praised LHINs as a long-awaited, necessary systems reform. Applying the concepts involved arguably may be very helpful for Ontario. However, in our view, the legislation, Bill 36, as it stands, will not improve the system and it appears to us to potentially create the opposite of what these officials praise.

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One rationale provided is to bring health care decision-making into the community. This is puzzling. The legislation clearly contradicts the intent to "allow decisions how health services are delivered to be made locally." There is no accountability for a LHIN or the health minister to the various communities within a LHIN; barely any local decision-making at all. LHIN board members are political appointees, meaning that no elected or community governance exists. The skills that were advertised for these positions were almost entirely managerial, financial and communications, which likely support political cost-cutting priorities but are hardly designed to effectively meet the health care needs in communities.

The process used to establish LHINs was undemocratic. Yes, some local health providers were involved,

but these people knew they had better co-operate while jobs would be streamlined and accountability and performance agreements would be signed. Unengaged were patients—who, by the way, received very little recognition in Bill 36 at all—and proven, responsible community groups. The consultations were held distant from the public, with very little notice. In my case, I found out about the Central East session in Markham through the Ontario Health Coalition. Otherwise, I would never have known. That was December 9, 2004. And yes, we have these committee hearings here, but isn't it pure irony that Central East citizens had to travel to Toronto to appear—and there were quite a few of us who applied—an indication, perhaps, of the travel dislocation LHINs may create to obtain health care services. So there was no real public process, no democratic requirements. You have to believe that that was intentional.

Instead, Bill 36 will restructure our health care delivery to provide incredibly new powers to one health minister and the provincial cabinet. We feel this is inexcusable. The minister will issue a strategic plan for the health system, a plan without public input. All LHINs must follow that plan. The legislation overrules all other related legislation, and its instructions are backed by court order. It demands accountability agreements to be signed by all LHINs, and when negotiations are unsuccessful, the agreements shall be politically imposed.

LHINs shall fund health care services according to what the minister considers appropriate, with a finite amount for one entire geographical area, hardly allowing for the flexibility required to solve unanticipated problems or needs within a very large, diverse geographical area. The Central East LHIN to which I belong includes Scarborough, the eastern section of the GTA, the Peterborough and Lindsay areas, and all kinds of stretches of rural areas. It's going to be difficult.

The minister, through a LHIN, will fund and restructure, but the scant appeal process does not apply to a community, or to patients for that matter. Non-clinical services in the legislation are defined very broadly, and that has created a direct threat for existing employee groups. Why would you want to do that?

Most important in the legislation is the ultimate power given to one minister or the cabinet to dissolve, divide, transfer and amalgamate service agencies that are not-for-profit. But the power will not apply to for-profits. These politicians can order the contracting out or privatization of hospital support services without community input. Undemocratically, the minister can determine who can and who cannot serve on a LHIN board and also which LHIN board meetings are public or closed, with just a notice provided. These are incredible powers within a citizens' health care system, but nowhere can I locate in the legislation powers or process for input that is local, as in "local health integration network." In addition, there is no accountability at all for the minister or cabinet.

We can readily see that the legislation is not regionalization or the local direction of health care delivery, but

pure centralization. If centralization is your goal, state it. LHIN boards and CEOs are accountable to the minister and not at all to the communities, toward whom there is no political accountability. All decision-making, in reality, is at Queen's Park, because LHIN directions will be based upon the minister's strategic plan. Central East local service delivery will be determined in Ajax, and we can expect disconnection rather than a more accessible continuum of care.

The primary purpose of the legislation appears to be cost-cutting—that should be publicly stated. If health care expenditures are politically burdensome, attention should be redirected instead to the spiralling cost of drugs and technology and the creation of a new expensive LHIN administration.

Bill 36 is actually only the enabling legislation. Imagine: The regulations are to follow. Bill 36 enables far too much.

I would like to raise some concerns from the local level—Peterborough and area—which perhaps apply to other communities as well. Provincial funding decisions, or non-decisions, lead us to believe that future restructuring will leave our communities ill served. Peterborough has not been well served under the minister's current strategic plan. Right now it's centralization, without local voices being understood. Why do we need a bill to enable just that?

(1) The restructuring in Bill 36: we've gone through this before. The Sinclair commission in 1999 identified the need for 483 hospital beds for Peterborough and area. St. Joseph's Hospital was closed, leaving one Peterborough Regional Health Centre. This single hospital has 379 beds, 40 of which are unfunded—104 fewer than we're supposed to have; 144 if you include the ones they don't pay for. The provincial government's two-year deficit elimination edict demanded—yes, demanded—\$8-million and \$12-million cuts, which led to a range of proposals cutting services and positions, which led to deep community outrage; in particular, pulling the women's health care centre out of the hospital jurisdiction. That was fought off. Jeff Leal, our MPP, helped us with that.

Peterborough awaits a second balanced budget plan formulated and negotiated in secret. That was covered in an opinion piece in the *Toronto Star* this morning. The sad Peterborough Regional Health Centre situation, with the highest emergency ward overload per capita in the province and a severe family doctor shortage, has been virtually ignored by the provincial government. This situation was all over the Peterborough media on the weekend because of the terrible conditions that sprang up once again: not enough beds, and for a long time, the province hasn't helped us.

The Peterborough and area hospital system has been restructured from without, but health care improvements did not follow. In our view, the Ontario government has restructured Peterborough into this deplorable situation.

(2) To assist with deficit elimination, our hospital, like others, was urgently encouraged to transfer services from

the hospital setting into a less costly community setting. Peterborough Health Coalition has agreed with this transfer concept, but only if the transferred service is sufficiently funded. For example, Peterborough had a stroke rehabilitation day hospital downtown that was funded one time through the summer months, ending on September 30. The program was transferred from the hospital, but the funding mysteriously dried up, despite community care access centre attempts to arrange promised funding and continue the program. It seems, at best, to be on life support at present, and we credit the access centre with continuing to revive the program with alternative delivery models. Where's the funding? The hospital did its side.

(3) The policy of transferring services from a hospital to a community setting will likely continue. According to Bill 36, the Peterborough community will not be able to decide the process or delivery. That will be done by the LHIN in Ajax, overseen by the ministry, of course. Local health care boards and community supports will lose the ability to make such strategic decisions.

(4) The Canada Health Act protects public delivery of, and access to, medically necessary services in hospitals and with physicians. When services are transferred out of hospitals or from physician care, the danger is provincial delisting of these services, which might lead to out-of-pocket expenses or revenue generated from other sources.

Provincial downloading continues as a public policy. Our local health unit, not the province, funded two nurse practitioner clinics for a few months to alleviate the effects of the family doctor shortage. The county municipality and the VON fund a similar clinic in rural Keene. Peterborough Health Coalition believes that as long as funding gaps created by the province can be filled by local revenue sources, which really is downloading, the minister or cabinet, through a LHIN, will accelerate the policy of transferring services from the hospital to municipal agencies, and unfortunately the funding may not follow.

(5) Family health teams, though in our view not as promising as community health centres, have the potential to serve more patients who don't currently have a family doctor; that's their purpose. However, these teams—and there are five in the immediate Peterborough area—are unfortunately, in our view, likely to become dumping grounds for the provision of services that have been transferred from the hospital or from the two clinics I mentioned previously that have been closed for lack of funding, which left 2,000 patients to scramble to a family health team barely in operation yet, or to the emergency ward. Such decisions would be made in Ajax. Certainly, in our estimation, Peterborough health care providers and citizens would not use family health teams this way.

A further general fear is that because LHINs are not actually regional health authorities that directly provide health services and labour, a LHIN will contract out the services to for-profit and distantly located companies. The latter will have less attachment to the community

than locally proven agencies and would be subject to less community input. Also, a competitive market system, rather than furthering integration, would create fragmented contracts driven to make profits that are forwarded to out-of-community head offices and would actually discourage information sharing and co-operation among providers in the interests of protecting their private information. Yet coordination is the alleged LHIN goal.

1530

We have at present a centralized system with enough empathy for our community. Why would we want centralization with excessive executive powers and decision-making out of the community? We don't look forward to more centralized, top-down decisions enabled by this bill, which over the last two and a half years, at least, have not understood and funded our community health care services adequately. Share the power with the community, which realizes its citizens' needs. We're going to be doing that in Peterborough a week from Wednesday: holding a public meeting and inviting all kinds of people, including our MPP, Jeff Leal. We're going to have all points of view there, and we're going to come up with recommendations. All political parties have been invited.

In conclusion, Bill 36 must be seriously amended, particularly regarding excessive executive power and the potential to displace community input and service delivery. At these hearings and in all Ontario communities there are groups, including our coalition, and individuals willing to help, but only if you stop, wait and listen more.

The Chair: There are 30 seconds each. Ms. Martel.

Ms. Martel: Maybe just a point, then: I'm glad you raised centralization of control. I referenced earlier today, and I'll do so again during the public hearings, some of the legal opinions that show very clearly that instead of devolving control to local communities, the government is actually centralizing that even more with respect to what cabinet can do, what the minister can do and then what the LHIN members can do. I remind you that the LHIN members are of course appointed by the government, not by the community. Thank you for pointing that out again today.

Mr. Brady: Can I just make a comment?

The Chair: Yes, quickly.

Mr. Brady: What I find regrettable is that it's a large bill and a lot of people haven't read it. The media in particular have not read it. They're reading the press releases and spouting them out. In Peterborough, we're trying to get that word out, and we've actually convinced a few people: "Hey, look a little further. This is centralization. It's not into the community."

Ms. Wynne: Two quick questions: First, do you think it's a good idea for the provincial government to have a plan for a sustainable health care system; and second, how did you get to the conclusion that the strategic plan was going to be developed without public input? I've been told, and my understanding is, that a process for public consultation is being developed as we speak. I'd like that information from you.

Mr. Brady: Okay. I'll answer the second one first. A strategic plan: You've had two and a half years. Other countries, other jurisdictions have delivered white papers which suggest where you're heading. That hasn't been done.

Ms. Wynne: So your answer is yes, there should be one.

Mr. Brady: There should be one—

Ms. Wynne: Okay, that's the first question.

Mr. Brady: —with public input, which has not happened so far.

Ms. Wynne: So how did you get to the conclusion that there's going to be no consultation?

Mr. Brady: I see no evidence that there is going to be. I tried to point out earlier that health care providers in the community were invited out, but the public was not.

The Chair: Mr. Arnott.

Mr. Arnott: Mr. Brady, I want to express my appreciation to you for coming in today. I don't know if you heard the minister's presentation this morning, but you have offered a very effective rebuttal to almost every point he made about what they're trying to do with this bill. You've highlighted very effectively, I think, the fact that this bill would appear to further centralize decision-making authority, really the opposite of what the minister indicated this morning.

The Chair: Thank you very much for your presentation.

AUDITOR GENERAL OF ONTARIO

The Chair: The next presentation is from the Office of the Auditor General of Ontario. Jim McCarter, please. Good afternoon. You can start anytime.

Mr. Jim McCarter: Thanks, Chair, and good afternoon. I've got just a one-page handout. I hope you have it. What I'd like to do is read a very brief statement into the record and then throw it open to questions, if that's okay.

Essentially, my comments relate to subsection 12(1) of the bill, which proposes that the Auditor General perform the annual audit of the accounts and financial transactions of each of the 14 local health integration networks.

We're concerned that the resource requirements of conducting these 14 audits, essentially across Ontario, would probably require a reduction—very likely a significant reduction—in the amount of value-for-money audit work that we currently conduct, especially now that we have been given the mandate to conduct such work in broader public sector entities such as hospitals, school boards, universities and community colleges.

Given that the LHINs are located in different geographical areas throughout the province, we believe it would be more practical and cost-effective for the board of each LHIN to appoint its own private sector financial statement auditors. Our research indicates that the legislation in seven other provinces covering regional health care organizations allows an organization's governing

board to appoint an independent financial statement auditor. Several other provinces allow for the appointment of the Auditor General to conduct the annual audit, but none require this.

I'd like to suggest that subsection 12(1) of Bill 36 be amended by removing the reference to the Auditor General and replacing it with a subsection requiring the board of each LHIN to appoint their own financial statement auditor. Although the Auditor General has audit access rights under the Auditor General Act, I believe it would be worthwhile to reiterate our audit access rights in the amended wording. Our suggested wording for the amended audit clause for subsection 12(1) would be the following:

"The board of directors of a local health integration network shall appoint an auditor licensed under the Public Accounting Act, 2004, to audit the accounts and financial transactions of the local health integration network annually. The Auditor General may audit any aspect of a local health integration network's operations."

I do not believe that accountability to the Legislature and oversight by my office will be impacted because, under the Auditor General Act, I would still be able to examine the accounts and activities, both from a financial and, probably most importantly, a value-for-money perspective, of any LHIN at any time should I consider it necessary.

I communicated the foregoing concern, together with our suggested amendment, to the Minister of Health and Long-Term Care by letter on January 3, 2006. The minister recently replied to me—it was late last week—and indicated that the government is prepared to propose an amendment to section 12 during the clause-by-clause review that would address my concern.

Although I am hopeful the government will remedy my concerns with respect to Bill 36, as an officer of the assembly, I did want to bring my concerns directly to the attention of the members of this committee and provide you with the opportunity to raise any questions you might have.

This concludes my presentation. I'd be happy to take any questions you might have.

The Chair: Thank you for your presentation. Two minutes plus for each. I'll start with Ms. Wynne, please.

Ms. Wynne: I'm just going to make a quick comment, and then my colleague Mr. Delaney's got a question. I just wanted to make sure it was on the record that the minister has said that he's open to an amendment, and whether or not it will be the exact wording is not clear at this point.

Mr. McCarter: Yes, the minister has written back to me and essentially said, "I hear where you're coming from, Auditor. I'm prepared to accept your suggested wording." My understanding is that it may not be the exact wording, but essentially he's onside with basically changing the act to have the local board appoint a local financial statement auditor to do the annual financial statement audit every year. So in Thunder Bay, they would probably take a firm from Thunder Bay; in Mr.

Leal's riding of Peterborough, they would probably appoint a local firm in Peterborough.

Ms. Wynne: And then you would have oversight of those audits.

Mr. McCarter: We have oversight to go in at any time to have a look at the audit. We would also have the ability at any time to go in from what we call a value-for-money perspective to any LHIN, to look at a number of LHINs for, say, best practices. We have the right under the Auditor General Act—because they would be basically recipients of public money—to go in at any time should we so desire. Quite frankly, we feel the time required to conduct 14—these are financial statement audits, where if they say they've got \$10,000 cash, do they really have \$10,000 cash? We feel our resources will be better utilized doing more broader public sector value-for-money audits or going into the LHINs and doing a value-for-money audit.

The Chair: Mr. Delaney. A quick one, please.

Mr. Bob Delaney (Mississauga West): You've actually answered most of the question, but perhaps you'd like to elaborate on it. Given that you expressed concerns on the resource limitations in your office, could you describe or perhaps elaborate a little bit more on how you'd set up a clear and consistent basis on which the 14 separate and independent audits could be conducted year to year on a consistent and repeatable basis?

Mr. McCarter: Within our office?

Mr. Delaney: Yes.

Mr. McCarter: Basically, we would have a team of auditors go into Thunder Bay or Peterborough and audit the LHINs. We'd have to do it annually; we'd have 14 audits. However, what would happen is, because we have staff going out and doing those financial statement audits, I know for sure it would mean I would have to reduce the number of value-for-money audits that I'm doing. We have the mandate now. We can go into hospitals and long-term-care facilities. There are hundreds of organizations we can go into that are getting hundreds of millions of dollars. I guess our preference would be—not telling tales out of school, but we are going for a fairly significant resource increase, hopefully, with the Board of Internal Economy. Notwithstanding, we would much prefer to use our resources doing more value-for-money audits as opposed to doing financial statement audits. That being said, if we had concerns about a financial statement audit, we would be in there pretty quickly.

1540

The Chair: Thank you. Ms. Witmer, please.

Mrs. Witmer: Thank you very much for coming to this committee, Mr. McCarter. I certainly support the amendment that you have put forward, and you can be assured of our support. Hopefully the minister will see fit to word it in the way that you have suggested.

You mentioned that in the other provinces, seven of them, the case would be that they would currently be in a position where they could allow an independent financial statement audit.

Mr. McCarter: All of them require, I think, an annual financial statement audit, but they allow the board the

authority to appoint, to make that decision. What would typically happen is that the board would probably give us a call and say, "Do you have any suggestions, Auditor?" We would suggest they go out for an RFP, basically put it out to public bid.

Mrs. Witmer: Okay. Thank you very much.

The Chair: Ms. Martel, please.

Ms. Martel: Thanks, Jim. As a member of the public accounts committee, I'm far more interested in your value-for-money audits than I am in your financial statement audits, whether it be of LHINs or any other transfer payment agency.

How did it happen, though, that you folks appeared as the auditor, not essentially of choice, for the LHINs? Did you see this before the legislation was introduced? Were you asked about it by ministry staff before then, or did you see it after it was introduced?

Mr. McCarter: To be honest, we were not consulted about it. We saw it in the draft bill. I'd have to say, though, that this has happened before, you know, "We have the Auditor General. We'd better make sure we get the Auditor General in there doing the annual audit." So I think it was just something, you know, they were drafting the bill, and there's typically an audit clause. They could have looked at other legislation like the LCBO act or something, where it said, "Appoint the Auditor General" and picked that up without giving us a phone call.

Ms. Martel: How many agencies, boards and commissions have the Provincial Auditor, or the Auditor General's office, doing the financial statements?

Mr. McCarter: There are probably between 40 to 50 where we're named. What we found, though, for the out of town ones is that it's probably more cost-effective for us to contract that out. For instance, I think of ONTC in North Bay. What we found is, when we get the firms in around the table—I don't say this too loud; it used to be with Arthur Andersen on the other side of the table—they sharpen the pencil pretty good. We actually got the audit for close to what we were paying for hotel, meals and transportation costs. We just feel it's a very cost-effective strategy to have the local firms do the audit, with some oversight from us.

Ms. Martel: I don't want to make comments about Andersen. I think I'll stop there.

The Chair: Thank you.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 431

The Chair: The next presentation is from the Ontario Public Service Employees Union local 431. You can start any time.

Ms. Sheryl Ferguson: Thank you. My name is Sheryl Ferguson. I'm very grateful for the opportunity to come and speak to you today.

I have many roles in health care in Ontario. I'm a patient, I'm a family member, I'm a provider, I'm an advocate for health services and I am a union representative. All of these roles are what bring me here today. I

am president of OPSEU local 431. We are the workers at the former Kingston Psychiatric Hospital and, since 2001, Providence Continuing Care Centre Mental Health Services. There are 604 members of our local. We are unique in health care in that we have one collective agreement covering all of our workers.

I'm also the communications coordinator of OPSEU's mental health division. This division of OPSEU is unique, as we have member locals from both the broader public service sector, where you will find most hospitals and community agencies, and the Ontario public service, where the two remaining provincial psychiatric hospitals are. At Providence Continuing Care Centre, I am a rehab officer. I work on the forensic unit, where I support the patients of the service in meeting their work and educational goals. I also have a large number of clients that I function as a case manager for.

I have many concerns about how this proposed legislation will impact on the members of this local, health care providers in general, my clients, my family and me.

When we look at overall health care spending in Canada, we see that we rank second to the United States due to large parts of our system that are presently being privately delivered. When private health care costs are calculated, Canada spends 10.7% of the GDP on health, still well below the 16% the US is forecast to spend. However, it is a cautionary statistic, particularly when we consider that the LHINs legislation opens the door to further private, for-profit delivery of health care. The fastest-growing expenditure in health care is actually outside the medicare system. If we wanted to make health care more sustainable, the logical conclusion, to me, would be to bring it more into the publicly funded, not-for-profit domain.

The local health integration networks are being presented as the solution to many of the difficulties Ontario is experiencing within its health care system. In fact, Ontario's health care system may not be so broken as to require such a massive, costly reorganization. The real cost drivers in the system are not addressed by this reorganization. For example, pharmaceutical costs made up 16.7% of health expenditures in 2004. Drug costs are not covered in this structure. Similarly, the shift to privatization has been a consistent cost driver. In home care, where the sector has undergone a massive shift from not-for-profit to for-profit delivery of care, costs have increased by 21.3% from 1980 to 2001. This has not been matched by a consistent service increase. When Ontario enacted a one-year funding freeze in 2001, service to patients was cut by 30%.

Ironically, the sector repeatedly targeted is the hospital sector. It is ironic because the hospital sector has been the star performer in Ontario's health care system. They have the shortest stays in Canada: 6.6 days, on average, down from eight days in the 1990s. Ontario hospitals treat more patients on an ambulatory basis than any other in Canada. They are the most cost-efficient. Ontario also has fewer hospital beds per capita than any other province in Canada. While funding to hospitals has exceeded the in-

flation rate, much of that funding has been targeted to specific initiatives. When core funding is distilled, in 2004-05 most hospitals received increases of 1% to 1.8%. That's from the OHA; not a group I would normally quote from.

According to an independent report in March 2004 by the Hay Group, Ontario's hospitals are more efficient than any others in Canada. The report shows that Ontario's hospitals have a lower potential for finding additional savings—a reminder of the efficiency measures that are already in place.

While local health integration networks have been touted as the solution to the integration problems within the system, key parts of the system remain outside the model. Physicians are left outside the system despite their role as the gatekeepers. Ambulance is left out despite the problems they face interfacing with hospitals. Public health is left out despite the lessons learned from SARS. Hospital laboratories are in; private labs are out. Psychiatric hospitals run directly by the ministry will be out; divested ones will be in. This cleaving of the health care system in fact creates more disconnect within certain sectors, such as mental health, than presently exists.

The weekend paper had this following headline: "A Health Care Quest." It's the description of one woman's 20-month search for a family physician in Kingston, and a family physician's description of how he is unable to retire because there are no family doctors in Kingston to take his place. I know this struggle well. Recently, I had to find a new family physician. I spent three months doing that, and I'm very fortunate. I happened to overhear a conversation of a new doctor in town and got in to him. My patients are not so fortunate.

There are approximately 40 outpatients registered with the service I deal with. Of all of them, I think there are approximately two who actually have a GP on the street. Otherwise they are using walk-in clinics, emergency rooms, and when all else fails, they use the family physicians contracted by the hospital who provide services to the in-patients. What this means is that my patients don't have ongoing preventive health care, they don't have a record and they don't have consistency in their care.

By leaving physicians out of the local health integration networks, many needs of the users of the system will not be met. I have many members who are forced to use our company doctor, and we find ourselves questioning, "Who is that doctor really accountable to? Is he accountable to us, to the patients he is seeing or to the employer who is paying him? Does our employer own our health records, do we or does the doctor?" That being said, my members have to go there because they don't have doctors and they need the services.

By going to the purchaser-provider model such as the CCACs, there will be no incentive to share best practices, given that facilities within any sector may face competition. My personal fear is that the integrated services that are common in mental health services will be carved out. Outpatient support teams such as ACT, case management and intensive community treatment may no

longer be able to provide the wide range of encompassing services they do now. Will cost efficiency mean that these teams will not have dedicated recreational specialists or vocational specialists, trained professionals who support, educate, mentor and, when necessary, handhold clients so they can meet their goals?

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The emphasis on making the system more sustainable suggests that the public is about to pay a price for this. The oft-cited example is of a number of hospitals transferring cataract surgery to a single factory-style clinic, yet when it is suggested that other services could follow the same route, we are called fearmongers. Under fiscal pressure from the government, the LHIN could very well rationalize many health services under the integration plan, forcing patients to travel hundreds of kilometres for services they presently receive in their community. While this may be efficient from a delivery standpoint, this is not efficient from a user standpoint.

Who pays for the flights, the hotels and the time off work to assist patients to travel to distant cities for treatment? For those who cannot afford these substantial expenses, are we creating a two-tier system? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on substantial personal expense?

The clients that I support cannot afford to travel outside of their home community for treatment. Just because they have a serious and persistent mental illness doesn't exclude them from suffering other health issues; actually, they're more likely to suffer other health issues. Medications often lead to weight gain and the health conditions related to obesity, including type 2 diabetes, high cholesterol and heart conditions. Many medications cause the need for ongoing monitoring of livers and kidneys. Many of my clients are hepatitis-positive. They will all need specialists in their lives, and if that access is not available in their home community, who will get them to and from their appointments? Who will provide the support after their procedure? Not their family physicians, because they don't have them.

In Prince Edward county, which is very close to Kingston, rationalization of services at the local multi-site hospital led to doctors announcing that they would relocate to other communities, worsening an already existing shortage of physicians. This also included the one and only surgeon at Trenton hospital. It would appear, though, that the hospital has been somewhat successful in recruiting more doctors—not enough to meet their needs, fully stated, but there are some coming, and there is another part-time surgeon coming to Trenton.

I am aware of at least five family physicians leaving Kingston in the last few months. That has left thousands and thousands of people without a primary health provider. It has also added to the already 20,000 people in the larger area who didn't have primary health care.

Kingston continues to struggle to recruit specialists. The hospital I work for has actively been recruiting a clinical director for the program I work for, for over a

year. Lo and behold, in this weekend's paper there's an ad for a psychiatrist too. I'm sure psychiatry is not the only specialty struggling this way.

Across Ontario, health care users are likely to experience more and more service transfers under LHINs. The LHINs are not a one-time restructuring, but rather a process for continual amalgamations, transfers and even the winding-up of certain services. This is a permanent instability within our system. While there are some limited protections for the workers under the Public Sector Labour Relations Transition Act, which Bill 36 proposes to amend, it is cold comfort to those who will be forced to choose between their community and their job. Workers are not always as portable as the government would like us to believe.

In mental health, we've been down this road. I've lived it, and I can tell you, it was not pleasant. Kingston Psychiatric Hospital was divested in 2001, and there are still outstanding issues around that. Yes, we did have a choice: We could not accept employment with the receiving hospital, and we could be unemployed. Some real choice we had there.

With the recent media attention on the divestment of ACTT teams in southwestern Ontario—from St. Joseph's Regional Mental Health, the former London Psychiatric Hospital and St. Thomas Psychiatric Hospital to community agencies in the Windsor area—my members are scared. They are asking if they have to face this again: accept job offers from employers they never really wanted to work for or face unemployment.

I do have many ideas on what we need to do with this legislation. I would like to say that human resources need to be addressed. We need to rebuild our health care system. We need to include front-line workers and the unions in it. Our health care system needs to be portable and equitable across the province. There should be no competitive bidding in health care.

We need to ensure that the Minister of Health is accountable and responsible for our system.

Employment stability will ensure the best patient care: Successor rights need to be restored to the OPS members; front-line staff, their bargaining agents and collective agreement must follow the work in any restructurings, transfers or sale of business; employment stability, no layoffs and a mandatory comparable job offer, seniority recognized and voluntary exit options are all necessary; and a human resources plan for all of the affected workers must be negotiated with health care unions.

The Chair: Thank you very much for your presentation. There is no time for questions.

HEART AND STROKE FOUNDATION OF ONTARIO

The Chair: The next presentation is from the Heart and Stroke Foundation of Ontario. Rocco Rossi, please.

Mr. Rocco Rossi: Thank you very much, Mr. Chair. I want to begin by expressing my appreciation and that of the Heart and Stroke Foundation of Ontario for the

opportunity to provide input on this important legislation. We are always pleased to offer our advice and input to the Ontario government, particularly when we see the government moving in the right direction to improve our health care system and address prevention.

However, before offering our positive comments, mixed with some cautions and constructive criticism, let me introduce our foundation. The Heart and Stroke Foundation of Ontario is a community-based, volunteer organization. Our mission is to reduce the risk of premature death and disability from heart disease and stroke through research, advocacy and public education. Every year, our organization funds some \$47 million in research in Canada, over \$30 million in Ontario itself, and awards another \$8 million to support young Canadian heart and stroke researchers. We are the largest nongovernmental source of research funds in this country. Here in Ontario, we work to educate the public and professionals, encourage healthier lifestyles and improve patient care and rehabilitation. With the perspective of our provincial scope, our foundation appreciates the need for the health care system to respond to the different realities in various parts of the province, including the need to take community needs and concerns into account in planning and setting priorities at the local level. Finally, the Heart and Stroke Foundation of Ontario recognizes that continuity of care is very important to patients and their families.

For all of these reasons, we believe that Bill 36 holds the promise of important and significant improvements in health care for the people of Ontario. This government deserves acclaim for developing the LHINs concept into sensible legislation.

We strongly support the goal of the legislation: ensuring that all Ontarians have access to the best possible quality of health care. Accomplishing this goal will save lives and improve lives across our province. However, if we are to accomplish those very laudable goals, some aspects of Bill 36 must be improved, both on paper and in implementation. The advice the foundation wants to share with you is not mere opinion; it is based on our many years of real-world experience and research across Ontario.

For example, we've been working with the Cardiac Care Network of Ontario on cardiac care issues, holding focus groups or soundings with a cross-section of stakeholders in every proposed LHIN area of our province. I know that you heard from Dr. Kevin Glasgow this morning regarding this important work towards an improved cardiac strategy in Ontario. We will be providing reports to the LHINs and preparing a composite report on the province-wide results.

For our purposes here today, you should know that the preliminary findings of this study underline a vital aspect of care that must be better integrated and supported in our system: that is, prevention. A shortage of family physicians and limited access to primary care in Ontario results in little time to devote to preventive measures. There is also insufficient emphasis on primary prevention

of heart disease and inadequate public awareness of measures to prevent cardiac disease. Our foundation sees the LHINs as key future partners in addressing these challenges, and we look forward to working with them.

Another relevant finding from this study to date is a common thread we are seeing across all LHIN areas and all services: the need for common and consistent protocols and standards. This and other issues exist across boundaries. No matter how sensibly you draw the lines, not everything is going to fit neatly within them.

Another useful lesson from these focus groups is that wait times need to be thought of in a comprehensive way. Cardiac care provides a perfect example of this. While the wait list after seeing a cardiologist appears to be under control, cardiac patients actually experience significant delays long before they are referred to a specialist. The lack of primary care providers and shortage of cardiologists means that there are real, significant barriers to access, regardless of what the wait list would suggest.

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Another source of lessons learned—our experience with the Ontario stroke strategy—underlines those conclusions. It also demonstrates the value of a regional planning approach and integration across the continuum of care.

The Ontario stroke audit of 2002-03 found an enormous disparity in the type of care and investigation offered to patients across Ontario. For example, 14% of ischemic stroke patients in LHIN area 11 received TPA while not a single patient in five other LHIN areas received that treatment. Province-wide, some 19% of stroke survivors have access to in-patient stroke rehab beds, but that number varies from 31% in one region to only 6% in another region. One is reminded of the wisdom of an old folk saying: Never try to walk across a river with an average depth of five feet. Averages and means do not tell the whole tale. We have geographic areas that need extra support and resources. I would be extremely surprised if this was not true for many, if not most, medical services.

So regional strategies and province-wide strategies, standards and protocols must be in place to ensure consistency of care. Just look at the establishment of secondary prevention clinics, which we supported as part of the stroke strategy: They have ensured that individuals with the symptoms of a TIA or mini-stroke are seen within days instead of months and they have made full diagnostic workups, together with lifestyle counselling, available to those patients. These clinics have reduced the admissions to hospital by 18.5% over a six-year period. We need to ensure that improvements like this are equally available in every LHIN area.

I want to return to rehabilitation for a moment because, to quote another folk saying, a chain is only as strong as its weakest link. Rehabilitation is certainly the weakest link in the continuum of care even though it is one of the most important. Pilot projects have demonstrated the tremendous potential of providing more in-

tensive rehabilitation in the community. We found that patients who received intense rehab had half the number of hospital readmissions in the first three months following hospital discharge. The usual care group was admitted for fractures and falls.

There's an interesting sidebar to this story. When we present this experience at conferences across Ontario, some participants comment that the enhanced care provided in their area is very similar to the usual care. It's just more evidence of the need for province-wide standards.

Any large, complex, cross-Ontario program needs guidelines. In fact, having a policy framework was one of the key success factors of the Ontario stroke strategy, and this committee would probably benefit from looking at the best practices guidelines and how framework development has been embraced as an ongoing process.

The other success factors we identified for the stroke strategy also provide a useful template for implementing integration through LHINs. Along with providing a policy framework, the key points were:

- the participation of clinical leaders, who played an essential role in the strategy's success;

- identifying change agents at the regional level who help make new thinking and new methodologies a priority;

- making a significant investment in professional education;

- providing a role for organizations such as our foundation, which has been very successful in bringing people together, engaging communities and identifying common issues; and the final point,

- engaging the public.

Let me just note that our public awareness campaign on the warning signs of stroke has increased awareness by 20%. That translates directly into more patients coming to hospital within the crucial two-and-a-half-hour window for initial treatment, which both saves lives and reduces the subsequent readmission, rehabilitation and disability costs to the system. The government's implementation of the ideas in Bill 36 could only benefit from a careful study of those success factors and the patterns and paradigms discovered in the stroke strategy experience.

Frankly, one of our concerns about the establishment of LHINs is that there will not be clear accountability at the provincial level to ensure continuing progress with implementation of the stroke strategy. This strategy must be continued for the sake of today's patients and those at risk of becoming patients in the future. It must continue to be the object of improvements, such as increased powers for the provincial and regional steering committees to hold health care providers accountable for integration. And, as I think members of this committee now understand, it stands as a highly useful and inspiring example of how to implement the kind of province-wide, systemic improvements the government hopes to create with LHINs.

Finally, I would like to mention two areas that the foundation feels are not adequately addressed in the

legislation. The first is research. I don't believe that Bill 36 even mentions the word once. True integration must include strong links to research so that we minimize the gap between what we know and what is practical. Good research has been the bedrock of our foundation's success and the wellspring of innovation and improvement. Please don't forget that you are not just building a system for now but a mechanism for distributing the fruits of progress in the future.

Our last point concerns accountability. I mentioned at the beginning our common goal of providing quality care to all Ontarians. This will only happen when information flows freely both up and down the chain, from Queen's Park to the front lines and back again; when those who have an intimate understanding of patient needs and critical issues are heard; and when those who make the final decisions are fully accountable for the choices and outcomes. The creation of LHINs and the introduction of Bill 36 are far more than first steps, but they are also not the end of the journey toward an integrated health care system.

This government has built on the efforts of previous administrations and the labour of many individuals and organizations to move Ontario closer than ever to our goal. With the leadership of government and through our continued mutual effort, I am confident of our ongoing progress and success.

Once again, I thank you on behalf of our foundation for the introduction of this important bill and for the opportunity to speak to you today.

The Chair: Thank you, Mr. Rossi. There are two minutes each, and I'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I would agree with you that rehabilitation is absolutely essential; in fact, I'm dealing with someone right now who has been funded to provide rehab services and has just discovered they're going to be losing the government funding come March. I know what a difference it has made in the lives of those people. So I think it is important that we continue to focus on what is needed and also that people throughout the whole province have the same access to the same services. I think you've pointed out that right now there is inequity and there doesn't seem to be any mechanism within the LHINs to ensure that everyone would have that service.

I want to thank you, and we hope that the government will be responsive to your concerns.

Mr. Rossi: I would be remiss in not taking this opportunity to thank you for the role you played, in your prior role, in making the Ontario stroke strategy happen.

The Chair: Madame Martel.

Ms. Martel: Thank you very much for being here today. Because you referenced the presentation we had first thing this morning from the Cardiac Care Network of Ontario, I was just curious as to whether you had seen the proposed amendments they've tabled with the committee.

Mr. Rossi: Yes, we have.

Ms. Martel: I'm going to assume, because of your reference to them and because they are pretty generic, that your recommendation for change would be the same with respect to legislative amendments.

Mr. Rossi: We're very supportive, and have discussed these issues on a combined basis. In fact, CCN is part of our cardiac soundings process across the province.

The Chair: Mr. Fonseca.

Mr. Fonseca: Rocco, thank you very much for your presentation, and it was great how you brought up some examples of the regional disparity that exists. Previous governments did not take care of that regional disparity. This government really has looked at the facts and at fixing the health care system, a system the Minister of Health did not see when he came into this role. What we're doing is building a stronger system for its sustainability.

Throughout your presentation, you addressed a lot of the regional disparities. Do you feel that with the local health integration network we will be able to better address those disparities than ever before, because it is based on CIHI information and fact?

Mr. Rossi: We certainly are hopeful, and we certainly see how the mechanisms for integration within a LHIN will lead to minimizing disparities within the LHIN. What we'd like better understanding on from the legislation and from the government—because you're devolving some significant powers into the LHINs—is how you still maintain and move toward addressing these disparities across LHINs. As you pointed out, they are not things that just appeared this year or last year but are systemic and have been long-standing.

Mr. Fonseca: Like CCN, you'd like to see that mechanism where province-wide—

Mr. Rossi: There are guidelines and protocols that can be used as a basis within the strategic plans of all LHINs to ensure that Ontarians, no matter what LHIN they happen to live within, will receive quality health care.

The Chair: Thank you, Mr. Rossi.

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ALZHEIMER SOCIETY OF ONTARIO

The Chair: We will have the next presentation from the Alzheimer Society of Ontario. Nancy MacArthur and Linda Stebbins, please. Good afternoon. You can start any time you are ready. You have 15 minutes in total.

Ms. Nancy MacArthur: Mr. Chairman, my name is Nancy MacArthur. I'm the vice-president of the Alzheimer Society of Ontario. With me is Linda Stebbins, our executive director.

I wish to thank the committee members for allowing us to present today. We will address five major issues. I have copies of our position paper for each of you, which contains the details on the changes we propose to address and our concerns.

Before Linda outlines the issues and proposals, I want to introduce you to our organization and our mission. The vision of the Alzheimer Society is a world without

Alzheimer disease and related disorders. One hundred years ago this month, Dr. Alois Alzheimer first described the disease we now associate with his name. Each year, we move closer to a cure for a disease that robs us of our memories and our loved ones. Along this path, our volunteers and staff have responded with compassion to the pressing needs of persons with the disease and their caregivers. It is our hope that our next centenary celebrates a world long rid of dementia.

But there is a shorter-term reality that we must face with eyes wide open. The national council on aging paper published in 2004 states:

"By 2031, Canada's biggest demographic group—the so-called 'baby boomers'—will move into the age of highest risk for developing AD. It is estimated that by that time, the number of Canadians who will have AD or a related dementia will have more than doubled from the 2001 figure of 364,000 to 750,000! ..., these costs will rise exponentially if prevalence projections remain unchanged. Some analysts believe that over the next 25 years, AD—together with other forms of cognitive impairment—will prove to have the highest economic, social and health cost burden of all diseases in Canada."

Our 39 Alzheimer Society chapters in Ontario and the provincial association have raised significant funds over our 25-year history. In the past three years, we have contributed more than \$37.5 million towards research and service to Ontarians. These funds have benefited research at the national and provincial levels in both the biomedical and psychosocial spheres. Dollars raised also underwrite support for people with dementia, families and caregivers, information and referral to community services, public education and Safely Home, the Alzheimer wandering registry. We also acknowledge the ever-increasing support from the province for our diverse range of in-demand services.

People with dementia require services across the health care continuum, from disease onset to end of life. We have an interest and a presence at every point on the continuum of care, partnering with family physicians to achieve better diagnosis and advocating for better pain management at the end of a person's life. We take a broad perspective on the health system and health care.

Ms. Linda Stebbins: As a result of this broad perspective, the Alzheimer Society is keenly interested in the evolution of Bill 36 and hopes to offer you a distinctive point of view on the current draft. We will identify five major issues for your consideration.

Issue (1) The primacy of quality of care: We have two parts to this issue.

Part A: The Alzheimer Society in Ontario believes the legislation should commit local health integration networks to high-quality care. A major concern of Ontarians is quality of care. The concepts of person-centred care provided in the right place and at the right time define key components of quality. Since LHINs will have responsibility for overseeing direct service agencies that have a duty to provide high-quality care, the LHINs themselves should share this duty.

Part B: The Alzheimer Society in Ontario believes that bills of rights in both the Long-Term Care Act, 1994, and the various acts governing long-term-care homes need to be reaffirmed.

Since powers in these acts may be delegated to LHINs, LHINs should also be bound by the bills of rights in these acts so that clients can expect consistency. The legislation before you has been criticized for not being client-centred enough. Reaffirming the rights of clients addresses this shortcoming.

(2) Caregiver recognition: The Alzheimer Society of Ontario believes that the role of informal caregiving merits recognition in Bill 36. While we benefit from a comprehensive and reasonably well-run health care system, it must be acknowledged that Ontarians, through kinship, friendship and community affiliations, provide most of the care to persons who need it. This is especially so in the care of the dying, the elderly and persons who are severely disabled by chronic diseases.

Most caregivers are women. Many face economic hardship that, in turn, creates new and unexpected social costs. Our system often fails to support caregivers. Caregiver respite was the first service typically jettisoned in cutbacks. For example, this was true when community care access centre budgets were scaled back a few years ago. It is also true now, given the pressures to meet the needs of acute care clients.

(3) Engaging clients and caregivers: The Alzheimer Society of Ontario believes that Bill 36 should specify that LHINs consult with clients and caregivers. Ontarians welcome the opportunity to engage with LHINs on key issues, but the current Bill 36 wording is vague on this score. Historically, district health councils drew a third of their members from the client, caregiver and consumer community, and the original community care access centre boards also provided for client membership. While we acknowledge the government's focus on skill mix for LHIN boards, Bill 36 needs to be more explicit about meaningful client and caregiver consultation and involvement. After all, the act provides a structure for service providers and health care professionals. The people they serve, as well as the persons providing the most service, deserve no less.

(4) Unreasonable encroachment: The Alzheimer Society of Ontario believes that Bill 36 unnecessarily extends the reach of government into the affairs of health charities. Our 25-year history is one of uncovering unmet needs and developing innovative services with funds raised from our communities. In time, some services have been funded by government and extended across Ontario. Our clients are appreciative, and we are as well. After the public sector assumes some of these costs, we continue to explore how, through charitable funds raised, we can deepen our supports to persons with Alzheimer disease and related disorders and their caregivers. An innovation currently underway in some parts of Ontario is the concept of respite bungalows, where persons with Alzheimer disease can go for a short time while their caregiver is relieved of their commitment. Other health

charities have done the same thing: hospices for the dying; services for the addicted; coffee houses for the mentally ill. These now are all a part of our range of services for Ontarians, all introduced by health charities in our communities.

The public sector needs to manage its resources, and we support LHINs having jurisdiction over funding from government. It is a principle of our parliamentary democracy that governments should only take on the powers required in order to achieve the goals for which they were elected. Section 28 gives the minister powers beyond what is required and which strike at the core of our civil society. We resist strongly the provision that the minister would have jurisdiction over the entirety of an organization with which a LHIN has a funding relationship. This, in our view, is unnecessary, unreasonable, counterproductive and, we believe, undemocratic.

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Some of our member chapters receive only a small percentage of their overall budget from government. For example, the Alzheimer Society of Toronto receives only 8% of its \$1.3-million operating budget from government. On the other hand, the Alzheimer Society of Elgin-St. Thomas receives 50% of its \$200,000 operating budget from the province. In neither case, however, should the minister have authority to interfere with our mission-related services that are not funded by government. Section 28 gives powers to the minister to issue directives on all of the Alzheimer Society activities. These powers need to be restricted to services funded by government, as per subsections 26(2)(b) or 27(3). Our accountability for charitable dollars should remain to our donors for purpose, and to the government for tax status.

(5) Diffusion of accountability: The Alzheimer Society of Ontario believes that Bill 36 can undermine the accountability relationship for both LHINs and health service providers. Section 25 enables a LHIN to integrate "persons or entities" with a "person or entity that is not a health service provider." Given that LHIN jurisdiction is restricted to health service providers, the subsequent accountability relationship of a non-health service provider is unclear. To whom is the non-health service provider entity accountable? Is it to the original health service provider? If so, what are the mechanisms for accountability? Are the contractual rights of the service provider compromised by the third-party interests of the LHIN? These questions demand clear answers. This section has the capacity to undermine the not-for-profit sector by transferring services, as defined in section 23, to the for-profit sector, blurring accountability and narrowing the LHIN and the minister's reach since it does not extend in an effective manner to the private sector.

In summary, the Alzheimer Society of Ontario appreciates this opportunity to raise these important issues, and we are confident that you will recommend amendments that (1) extend the rights of clients already found in other legislation; (2) recognize informal caregiving; (3) assure clients and informal caregivers of engagement; (4) cir-

cumscribe LHIN and ministerial powers so that charities are not jeopardized; and (5) clarify accountability relationships.

The thousands of Ontarians with Alzheimer's disease and related disorders and the thousands more who will contract it benefit greatly from our partnership with government. We have outlined how Bill 36 threatens this collaboration, and our proposed amendments show how Bill 36 can be improved. Ontario and Ontario's health system was built upon such partnerships, and this is where our future lies. We ask for your support for our amendments.

The Chair: Thank you for the presentation. There's no time for questions.

YWCA OF PETERBOROUGH, VICTORIA AND HALIBURTON

The Chair: The next presentation is the YWCA of Peterborough, Victoria and Haliburton. Lynn Zimmer, please. Good afternoon. You can start any time you're ready.

Ms. Lynn Zimmer: Members of the committee, my name is Lynn Zimmer—kind of ironic. I am the executive director of the YWCA of Peterborough, Victoria and Haliburton. Our YWCA is a 115-year-old women's equality-seeking organization which promotes the leadership of women and supports the right of all women and their families to live free from violence, poverty and oppression. We bring four issues to this consultation. I can't critique your specific plans because I don't know what they are, so I'm going to share some thoughts and concerns.

Transportation is my first topic. Transportation is a big factor in our health care challenge, but it is not yet adequately included in the health care system. In our region, travel for medical services is already a huge burden, particularly for single individuals, single parents, people with low incomes, elderly people and people with disabilities. Women are a large part of all of these groups. Please note that when health care is the issue, disability may be lifelong, recent or temporary. Disability can be the reason that health care intervention is needed. It could be a symptom of a new or old problem. It could be caused by medications, by anxiety or by the treatment itself.

People in our region already face huge travel burdens when seeking cancer treatments, for instance, or when seeing specialists in Toronto or Kingston. Rural people are the most disadvantaged. The trip from the village of Haliburton to Peterborough in midwinter can be harrowing, but there is no public or private transportation, except perhaps from Peterborough. So you can call a taxi from Peterborough and, for a mere \$143 one way, you can get yourself down to the hospital.

For people already marginalized by poverty, mental health problems, isolation or lack of social connection, and for those who are elderly, alone and poor, lack of transportation means no access to health care. No one

wants to travel when they are ill, and many just can't. There's a lot of talk about shortening wait times for hip and knee replacement surgery. The idea is to preserve people's mobility and thus their ability to live independently. No one ever talks about how they get home after their surgery.

A friend of mine lives in a community north of Peterborough. It's called Buckhorn. It's about a 20- to 25-minute drive. Her parents, who live nearby, are both in their 80s and both are battling cancer. Her mother has had to travel back and forth to Peterborough and Kingston for her breast cancer treatments. Her father has to travel to Peterborough and Toronto for treatment for prostate and bladder cancer. When her dad was hospitalized in Peterborough, her mother cancelled her remaining treatments so she could be with her husband for his, and she has had to travel back and forth every day to visit him. The entire family is exhausted from the combination of treatments, travel and worry. These people are lucky: They have immediate family members to do the driving. Most are not so lucky. Many take to the roads when their health status makes them marginal drivers at best. Many give up. They're too independent to ask for help, and they don't know who to ask. Taxi fare one way from Buckhorn to Peterborough is \$55.

It is our recommendation that the new system should determine a maximum travel distance for treatment—which should be shorter than the one we have now—and implement a system of transportation supports suitable for people coping with pre- and post-treatment pain, fear, anaesthetics and disability. I understand that changes would actually be needed to the Highway Traffic Act to add extra busing to help people get back and forth, for instance, because our current arrangement allows for only one transportation provider per route. So local organizations that want to organize not-for-profit busing are precluded from doing so.

The next issue is the lack of democratic process and community input. We've heard a lot about that today, and I think that some of the very concrete advice you've had from some other presenters may be even more to the point than mine.

Communities and equity-seeking groups have had no input into the LHIN's design and we have no assurance that the LHIN planners will create a system that responds to the needs of the most vulnerable and unprotected people. If our health care system is to be truly responsive, how do we access the decision-makers? To whom do we present the stories of good service or tragic lack of service? How can we compare the barriers faced by a family in Buckhorn or Haliburton to those of someone who lives near the subway station in Scarborough?

The members of this committee may end up feeling that many of the presenters are afraid of change, that we see only the worst possibilities. Maybe we seem paranoid. Partly that's because we have no solid information and no assurance about the core values that are really driving this process.

I'm generally considered to be a fairly positive sort of person, but I have a nightmare image that haunts me. I

am a very old lady and I wake up in a hospital-like setting, alone and frightened. I don't know how I got there. The worst part is that my husband is in another institution, also alone. We don't know where each other is and we both feel abandoned. No one helps us find each other or communicate. Each of us is seen and treated as lone patients with no connections. We have no children to act as our advocates. When I've presented this picture to people in the health care sector, no one has ever been able to assure me that it couldn't happen.

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It is images like these that haunt health care advocates. We see the human care in the health system disappearing. It becomes less and less likely that we will be treated by a doctor who knew us when we were well. The bits and pieces of our bodies and minds are analyzed, poked and treated, often in different facilities and different cities, as if they were all separate from who we are and how we live in the world.

The health care needs of women: Peterborough's Women's Health Care Centre is a unique and valuable feature of health services in our region. We will fight very hard to retain it. In fact, its services should be expanded and given greater financial support. If our health care system is truly to become preventive, then women need access to community-based resources that help them educate themselves, make informed choices about their health and that of their families, and access services that support their right to make their own decisions about their reproductive and general health. More communities should have a women's health care centre, not fewer.

Now that most procedures are done on an outpatient basis, women pick up a huge proportion of the down-loaded impact of patient care. This includes transportation, aftercare, monitoring of medication and post-op care for close family members. Yet even the simplest tools, like a written description of the homely details of recovery and aftercare, are often simply not provided.

A little thing like parking fees can break people. In Peterborough, a state-of-the-art long-term-care facility has been built on the outskirts of the city. Bus service is available, but anyone who must drive because they come from outside the city must pay a \$2-parking fee each visit. That's \$60 a month, if you're making daily visits. For a low-income woman, that can mean not enough money for food. Yet those daily visitors are a critical part of the health care system.

Finally, human beings are capable of generating powerful healing energy from within themselves. Research has shown the power of guided imagery, the power of positive emotions, the power of hope and love to influence a positive health outcome, even for people who are critically ill. As we continue to slice and dice and centralize care, what is being done to harness this energy and power, to work with it instead of against it?

Treating the whole person and keeping their lives intact in the midst of all their support systems is important. Bring treatment closer to the people. Don't add

unnecessary trauma and delay. Don't ignore all the barriers we have to overcome to access the system.

In summary, we want a system that understands that we human beings are the real source of healing. The professionals and caregivers bring their healing skills. They bring experience and compassion, not just their organization skills and their ability to operate machines and their cost-effectiveness. The patients bring their hope, their resiliency and their power to help themselves.

Women are the unacknowledged aftercare providers. They need to be included in your thinking, and they need more information and community supports to help themselves and their families.

Access to transportation to and from consultations and treatment must be considered in any health care planning. Thank you.

The Chair: Thank you. There is about a minute and a half each. We'll start with Ms. Martel, please.

Ms. Martel: Thank you for being here today. I just wanted to focus on transportation from the perspective of the concerns that are being raised with me from my part of the world, which is northeastern Ontario. I live outside of Sudbury, but not that far outside of Sudbury. But there are many from northeastern Ontario who would drive from Timmins, three hours away; the Soo, four hours away; North Bay, an hour and a half away, to access care at the regional centre. The concern they see with this bill is that the move will be afoot, essentially, to rationalize services from those hospitals into the regional centre, which would be ours, to our benefit, but to the extreme detriment of those who would then be on the road for even more services.

I have a concern from that perspective. Now people who don't have to travel or who travel very little, because they can access that service at the Soo and area hospital or at the North Bay General, are going to end up losing that and then having to drive, with all of those complications when you are unwell, or having someone drive them into Sudbury for some of those services.

I don't know if you want to comment on that. You've commented on how difficult it already is for existing services, if they don't move anywhere. I'm cognizant of that, and I'm also very concerned about what's going to happen if some of those start to move from smaller centres to larger, from smaller hospitals to larger hospitals.

Ms. Zimmer: I think there are many, many services that really do need to continue to be available at many places, and as close to people's living communities as possible. The issue of what things get centralized and require long-distance travelling is a critical issue, and there should be as few of those as possible. I don't know how that is rationalized with cost-effectiveness, but people can actually be made more ill by the stress of getting to their treatment than the treatment itself.

The Chair: Thank you. Mr. Fonseca.

Mr. Fonseca: Lynn, thank you very much for your presentation. I'd like to bring up that when the minister developed this and the ministry looked at LHINs and at

driving care into the community—I'll give you an example: Cardiac care post-op and rehab programs were taking place in hospitals. I was at one recently where it cost \$12 a day to park and people were coming in a few times a week. That's \$30 or \$40 a week. Today what we're doing in terms of driving that care into the community and that best practice is moving it into things like the YMCA—there's a program set up with the YMCA—or the community centre, where a nurse can also be there. Rather than having those people come into the hospital and pay that \$12 a day, it's closer to their house. They have gotten their operation at the hospital and now they've moved into their community. They can almost walk across the street, many of them, and do that rehab in a place they find more appealing than going to the hospital a few times week. Those are the innovative ways and best practices to better the system and make it more patient-centred. Do you agree that would be a good practice to follow forward with?

Ms. Zimmer: Yes.

The Chair: One more quick question for the government.

Ms. Wynne: Very quickly: You talked about transportation and that those guidelines should be in the plan. Do you see that as part of a provincial strategy? Do you see those guidelines at the provincial level?

Ms. Zimmer: I think so, because it's really an equity issue, so there has to be some kind of principle about what people should have to go through to get to their health care.

The Chair: Thank you. Ms. Witmer, please.

Mrs. Witmer: Contrary to what Mr. Fonseca has just said, we want to talk about cardiac rehabilitation. Our government actually did set up cardiac rehabilitation programs outside of the hospital settings. In fact, I have one right here: the Ontario Aerobics Centre in Breslau. We provided funding because we thought people should be getting the opportunities outside of the hospital. I have to inform you that they have now been advised by the ministry that perhaps as of the end of March, their funding may be discontinued. So all those patients who thought this innovation was a wonderful thing will lose the opportunity for cardiac rehabilitation in a setting outside of the hospital. I just wanted to let Mr. Fonseca know that we did introduce this type of innovation. Obviously, we're very concerned for the patients who are going to suffer the consequences as a result when this is no longer funded.

Thank you for your presentation.

The Chair: Thank you very much for your presentation.

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CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1909

The Chair: The last presentation of the evening is from the Canadian Union of Public Employees, local 1909, Lindsay/Kawartha Lakes, in the Peterborough area, I believe; Melissa Lotton and friends.

Ms. Melissa Lotton: Friends, yes. These are my supports.

The Chair: Welcome, and you can start any time.

Ms. Lotton: I am brand new to this—I've never done this before—and I ask you to keep that in mind. I'd like to introduce my colleague Doug Allan, from CUPE, and my colleague and co-worker Maggie Jewell, who has worked as an RPN for 23 years at Ross Memorial Hospital and is also president of local 1909.

I am Melissa Lotton, a registered practical nurse, mother of two and a taxpayer. I live in what is to be LHIN number 9. I have worked at Ross Memorial Hospital for the past 15 years and I am just now allowed to use my nursing education to full scope. I am also vice-president of CUPE local 1909 and I am considered part of support services, which is threatened to be removed from the hospital by Bill 36. I was born and raised within this community and find I am very concerned about where this LHIN legislation is heading. I feel that the public has been directly eliminated from any input on this legislation.

With regard to centralization, I feel LHINs are local in name only. Local communities and providers will lose the ability to make decisions. LHINs will have the power to turn delivery over to for-profit corporations. More bureaucracy will be created, which in turn will be unaccountable to the local communities, will undermine health care and social services and remove the accountability from the government.

LHINs will not be able to increase revenue, so to me, it seems that smaller communities may be the first to see their services joined with other communities.

LHINs are not local; rather, they are far too extensive, as our local area services from Algonquin Park to east Toronto to Cobourg and Campbellford. Where is the "local" in that? Our population doubles in the summer as we are cottage country, and our hospital has recently undergone renovations to help accommodate the increasing patient volume and the modernization of health-care delivery.

Public, tax-paying people should have their input into the geographical areas of the LHINs, as well as a voice if and when proposals, amalgamations or divisions of LHINs may occur, as we are the people living in those areas.

Patients and their families requiring the use of health care will have to travel further distances for routine procedures, which need to remain in their communities. Travelling will create two-tier care for those who can afford to travel and pay and those who will not be able to pay. In our community, the next-largest city to us is Peterborough, which is 45 minutes away, and there is no public transport. Are we to assume that the government is going to use ambulance service to transport patients, as they are not at this time included in the LHINs? Our hospital, along with many others, is currently using private transport systems for our public.

Ontarians deserve the right to know when, where and what is happening to their health care. Health care must

stay public and must stay in our communities. This is what we call local health care. Privatization will bring disintegration with the multiple providers that will be in competition to win contracts. Competitive bidding should not exist in health care legislation, but we need consultations to develop appropriate funding formulas for the LHINs and service providers.

Privatization creates unstable job security such as that faced by CCACs, with home care workers needing to leave their chosen professions due to poor wages and unstable working conditions, such as contract renewals. If our CCACs are reduced by numbers from 42 to 14 to match the number of LHINs, how will they ever cope with the overwhelming workload, not to mention the geographical demands they will have to service? Privatization will create specialized services spread out over many different health care providers, which in turn will create more problems for those with multiple health issues, of poor social standing, the elderly and their families.

Although hospitals provide many diagnostics, surgical clinics and laboratory services, privatization will remove these services and therefore turn them into private clinics that increase their cost. Profitable private services will become priorities at the expense of other services. Once again, those who can afford to pay will receive and those who cannot will do without.

LHINs, Bill 36 and the privatization of our health care services will join us with other countries, countries that have envied Ontario for having one of the best health care services in the world. As a member of CUPE, I ask that we be included to participate in the talks to aid in the redevelopment of a health care system that everyone can be proud of.

Privatization will create an end to one-stop hospitals. With access to services being at the forefront, it is imperative that Bill 36 not give the government and the LHINs the ability to restructure public health care. Integration decisions force not-for-profit health care providers to cease providing services or to transfer such services, but for-profit providers are exempted from this. Bill 36 gives the authority to contract out services despite the needs dictated by the hospital.

With the threat of reduced community control and LHINs being given power to fund and manage health care and social services, is this to mean that services will vary from LHIN to LHIN? This will not unite service providers but will increase competition between providers. What purpose will be served if integration creates new and higher costs? Bill 36, the minister and LHINs must include public input, push for not-for-profit services and refrain from ordering direct integration.

Legislation should not in any way override the terms and conditions of freely negotiated or arbitrated collective agreements to protect their health care and social service workers. Front-line workers such as support services are a priority in the health care field, such as the workers who dealt directly with SARS. They deserve reasonable employment, security and protected working

conditions. Bargaining unit rights and collective agreements must be adhered to. Health care and social service workers have been through many rounds of restructuring, and their collective agreements cannot be overridden by this legislation.

In conclusion, I feel the government's attempt to change health care as we know it is going about it the wrong way. The community, health care workers and the public need to be included in health care reform. I believe in the democratic process and had no idea this would be the direction the government decided upon in restructuring our health care. As a front-line worker and a registered practical nurse, I ask that section 33 of Bill 36, where the cabinet can order the transfer of non-clinical services out of the hospital, be removed from the legislation. Privatization of these services will decrease the high standards that are now in our hospitals.

I thank the committee for listening to my concerns and hope for a positive outcome. I will be attending the health coalition meeting in Peterborough on February 8 to offer my support and hope that others who hear me will join me at the Evinrude Centre.

The Chair: Thank you, Ms. Lotton. There are about six minutes left, so I'll start with the government; two minutes.

Mr. Leal: Melissa, thanks very much for your presentation. The Central East LHIN is under the chairmanship of Foster Loucks, who is a former chief administrative officer for Haliburton Health Services and who formerly served on the St. Joseph's Hospital board in Peterborough. There's no question that in Haliburton or the city of Kawartha Lakes, in summertime there is increased pressure. Don't you think that with Mr. Loucks representing your area, he can bring his experience to the table to establish priorities and get funding for that particular area of the LHIN that has increased pressures, particularly during the summer months? Have you met with Mr. Loucks?

Ms. Lotton: No, I have not.

Mr. Leal: Do you know of him?

Ms. Lotton: I've heard his name a few times, but that's about all I know of him.

Mr. Leal: Could you just respond in terms of setting priorities because of the increased pressures you have, particularly during the summer months? You're on the front line there. I'm interested in getting your response.

Mr. Doug Allan: The problem is that there really is a dramatic lack of democratic control within the structure that is envisaged to date. While there may be good people, in some cases, who have been appointed to the board, what we would actually want is genuine community control that would see the process unfold better, a more democratic process and not a government-controlled process. That's what we need.

Ms. Wynne: A quick comment. I just want to know whether you understood that section 33 is a transition clause that is there to facilitate some processes that are already under way in terms of amalgamating hospital business services. I didn't know if you were aware of that.

The second point I wanted to make was that you talked about the reduction of CCACs. The offices will remain—the administration will be integrated, but the offices will remain—so that interface with the community will still be there in the offices that are already in place.

The Chair: Thank you. Mrs. Witmer or Mr. Arnott.

1650

Mrs. Witmer: My question to you would be, what is your biggest priority in terms of what the government should do with Bill 36? What is most offensive, or what is the biggest change needed?

Ms. Lotton: I just want to focus on keeping our general hospital for ourselves there in that community. I'm not looking forward to services being cut, services being moved from here to there, everywhere. Support services are very important in a hospital when it comes to infection. If we could have more public involvement so that, say, my grandmother could understand what's going on with this bill—because in all reality, other than us, the immediate people talking about it, I don't believe that anybody has a clue about what's going on with their health care. I think what's going on with our health care needs to be brought more to the forefront.

Ms. Martel: I want to return to section 33 and read it into the record. It says, "The Lieutenant Governor in Council"—that's cabinet—"may, by regulation"—that's behind closed doors, not through legislation—"order one or more persons or entities that operate a public hospital ... to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date." I don't know what the reference to "transition" is. I know the legal opinion from Sack Goldblatt on this particular provision is that it allows government to order any hospital to transfer its non-clinical service to any entity and there's no limitation on the nature or the structure of the service or to whom it may be transferred. So when you talk about contracting out a service, that's where the reference comes from. The particular legal opinion that looked at that also said that's where you're going to see dietary, cleaning and housekeeping services, for example—many of whom are CUPE members, though I appreciate it might not be you folks—see their services privatized regardless of what the will of the local hospital board might be. That's the power we're talking about there. I don't know what the reference is to "transition." I look at that and say, why are we giving the minister authority over a hospital board to order privatization of those kinds of services? I don't think that should happen in anybody's community. I certainly don't see what the appeal is here, because there isn't an appeal mechanism, if the minister decides to do that. What do you think about that?

Mr. Allan: I think that's an excellent point. Ms. Wynne raises this idea of transition. What we've been informed is transitional—you may be referring to the hospital business services which are being established over the 14 GTA hospitals. That will see 1,000 people transferred out of employment with the hospitals to the

HBS, with 20% to 25% of those people then severed and services then contracted out. That's the information they provided to us. I'm not sure what the government is telling you, but it is not just the first or the only example of support service regionalization that they're looking at. We know this is happening in many, many different locations. If there is some sort of transitional nature to this, not only should that power be capped and ceased but it should be explicitly put in the legislation that the sort of contracting out this legislation contemplates should not be permitted and should be stopped. If we wish to preserve integrated hospital systems—not fragmented, multiple employers—with decent conditions for the employees at the facilities themselves, that's what's at stake here, and that's what I think you people inside the government have to stand up for if you're going to maintain credibility.

The Chair: Thank you for your answer and for your presentation.

This is the end of the presentations, but there is a motion before us that was introduced at the beginning that we should potentially vote on.

Are there any comments on the motion? We all have it in writing. There are two things: We are asking that we deal with Bill 210 clause-by-clause on February 15, and that the deadline for amendments be noon on Friday the 10th. We need permission for that. Yes, Ms. Martel?

Ms. Martel: I asked about this earlier because I wanted to be able to check with our folks to see who actually sits on the committee to make sure they were aware of this and that it was fine. I thought we were getting this much earlier in the day so I could actually talk to someone about it; I haven't. I'm happy to try and deal with it tomorrow morning now that I have the motion in front of me, just to see who sits on the committee for this particular bill and make sure that the other committee members—because I wasn't party to this conversation—are aware of it and are okay. Can we do that?

Ms. Wynne: That's fine. I thought you had the information, but that's fine; we can do it by tomorrow morning.

The Chair: To prepare for tomorrow, can I ask both of you to please consult so we—

Ms. Martel: Now that we have it, yes.

The Chair: Mr. Arnott?

Mr. Arnott: I have another question. Maybe I'm missing something, but a standing committee of the Legislature needs the authority of the House to sit when the House is not sitting. As I understand it, the House comes back on February 13, so why do we need the approval of the House leaders to sit on February 15?

The Chair: Normally we sit Monday and Tuesday on this committee, and this is for a Wednesday. It's out of the norm.

Mr. Arnott: But it would still require a motion of the House, right? So it's not really in our hands anyway, other than that we can ask for it.

The Chair: I guess it's important for us to know—

Ms. Wynne: If they agree.

The Chair: So again, we'll deal with this tomorrow. Is that the agreement? Thank you. That is all for the evening.

The other issue that we may want to discuss is that we can leave any time, but I understand there has been a

request to leave at 6. Can we all agree that we meet at 6 at the main entrance, the south entrance? There will be a bus to take us to the airport at 6. Does anyone have a problem with that time? Okay.

The committee adjourned at 1655.

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Tuesday 31 January 2006

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Standing committee on social policy

Local Health System
Integration Act, 2006

Comité permanent de la politique sociale

Loi de 2006 sur l'intégration
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 31 January 2006

Mardi 31 janvier 2006

The committee met at 0902 at the Four Points by Sheraton, London.

services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

COMMITTEE BUSINESS

ADDICTIONS ONTARIO

The Chair (Mr. Mario G. Racco): Welcome to London. We are here on our second day hearing deputations on the LHIN act. We are happy to be in London, Ontario. Our first deputation is from the Oneida Nation of the Thames.

The Clerk of the Committee (Ms. Anne Stokes): They're not here yet.

The Chair: They're not here yet. Ms. Wynne?

Ms. Kathleen O. Wynne (Don Valley West): I'm wondering if we could deal with this item of business just very quickly, the motion regarding February 15 and the clause-by-clause for Bill 210. Would you like me to read it?

The Chair: Fine, for the record.

Ms. Wynne: I move that the standing committee on social policy meet on Wednesday, February 15, 2006, for clause-by-clause consideration of Bill 210; that the deadline for amendments be noon on Friday, February 10, 2006; and that the committee request the House leaders' authority to sit on February 15, 2006, outside its normally scheduled meeting time.

The Chair: Any debate? Any questions? Anyone in favour of the motion? Anyone opposed? The motion carries.

Should we move to the second presentation, if they're in attendance? It is Addictions Ontario. Anyone here? None? How about the Canadian Union of Public Employees? Is anyone present here with us this morning who has to make a deputation? No one? Well, if that is the case, then unless there is any other new business, we'll just wait until the first deputants show—unless any of you have anything else that you want to debate or discuss. So until I recall, you can have a break. That's a good way of starting the day.

The committee recessed from 0904 to 0909.

LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health

The Chair: Good morning again. We will restart the meeting. I understand that Addictions Ontario has arrived, and I ask that you please make your deputation. Since our first deputant is not here yet, we thank you for starting earlier.

Mr. Jeff Wilbee: Our pleasure, sir. Good morning.

Ms. Catherine Hardman: Good morning. I'd like to thank you for this opportunity to make this brief presentation to you today. I am Catherine Hardman. I'm the president of Addictions Ontario, which is an organization representing over 120 addiction service agencies and resources across Ontario. My colleague is Jeff Wilbee, the executive director of Addictions Ontario.

We wish to make several points regarding Bill 36. First of all, Addictions Ontario supports Bill 36 because we believe authorities operating at a level of aggregation smaller than the province as a whole and with a mandate to promote service integration and coordination are necessary. We say this for two reasons. Many clients of addiction services have multi-dimensional needs, not all of which can be met by addiction services. Accordingly, a more integrated service system would expedite access by our clients to other health services they need. Many users of other health services have problems that are caused by, or made worse by, their substance abuse or problem gambling issues. A more integrated system would expedite access by these other service users to the services of the addiction system.

Much service integration has already taken place as a result of efforts by addiction service providers to work in co-operation with each other and with other parts of the health system. The creation of LHINs legitimizes, supports and extends these efforts.

We have concerns about the vast geographical areas covered by some LHINs. We recognize that the determination of LHIN boundaries was made as a result of an analysis of population sizes and hospital service patterns. However, we do not believe that a LHIN can be considered local when, for instance, it covers an area stretching from the border with Michigan to the shores of James Bay. Indeed, the LHIN that we are in today, the southwest, encompasses Tobermory to St. Thomas. In

effect, LHINs are regional rather than local in terms of focus and area covered.

We note, however, that Bill 36 contains flexibility to allow LHINs to evolve, if and when necessary, into bodies that are truly local in nature. The bill specifies that, "The Lieutenant Governor in Council may, by regulation, amalgamate or dissolve one or more local health integration networks, or divide a local health integration network into two or more local health integration networks."

Bill 36 also seems to contain sufficient flexibility to allow the creation of both local and regional capacity to create a more integrated system. This flexibility seems inherent in the bill's provision, section 6.3, that "A local health integration network shall not exercise the following powers without the approval of the Lieutenant Governor in Council ... creating a subsidiary." We interpret this to mean that a LHIN can, in fact, create a subsidiary provided that the LHIN has prior approval of the Lieutenant Governor in Council. If our interpretation is correct, we welcome this flexibility in Bill 36.

Under Bill 36, a LHIN is empowered, under certain conditions, to make an integration decision about a health service provider that would cause the provider to effectively cease to be a LHIN-funded service provider. For many service providers who rely entirely or almost entirely on LHIN funding to operate, this would be tantamount to causing them to cease to exist as a service provider, even though the LHIN could not cause them to cease to exist as a legal entity.

Bill 36 provides an appeal process for the provider after such a decision has been made by the LHIN. However, it does not require the LHIN, in advance of the decision, to consult with, meet with or otherwise engage the provider in any discussion of factors that would lead to the decision under consideration by the LHIN. A requirement to consult with and enter into discussion with a provider prior to such a decision by a LHIN should be included in the legislation.

We can envision situations in which a LHIN is concerned about the operation of a provider and the LHIN may consider making a draconian decision as a way to deal with this concern. However, we believe a degree of negotiation between a LHIN and a provider to determine if there is an appropriate and mutually acceptable way to deal with the concern is the preferred starting point for resolving any such concern.

Embedding in Bill 36 a notification and discussion provision would not prevent a LHIN from ultimately making a decision if it is not satisfied with the result of the discussion; nor would it prevent the provider from making an appeal to the LHIN after such a decision is made.

Subsection 16(1) of Bill 36 refers to engagement of community. The role of networks, LHIN region or broader, in the health care system is important in setting standards and providing voices for providers, their clients and members of their families. A liberal interpretation of this subsection clearly should include the input of

networks, but we are concerned that a more conservative view could exclude input from this very valuable resource.

We therefore recommend that the term "community" be defined in section 2, with the definition including "networks" and "provincial associations."

We are concerned that the wording of subsection 16(2) of Bill 36 limits participation in the advisory committee process to regulated health professionals. It has been estimated that there are over 40,000 counsellors and therapists offering quality services to clients in the addiction and mental health field who will not have a voice at the LHIN. In fact, most of the human resources dealing with those suffering from addiction and mental health problems are not regulated.

We therefore recommend that the wording of the section be amended to delete the term "regulated."

Section 28 gives the minister a number of powers, all of which he or she is required to exercise in the public interest. Previous legislation, recently enacted, provides some guidance to the interpretation of the term "public interest."

We would recommend that the wording of Bill 8, the Commitment to the Future of Medicare Act, 2004, be incorporated into this legislation and that the wording further includes "prevention," "brief intervention" and "determinants of health."

We note that under Bill 36 the objects or purposes of CCACs remain largely the same but with the addition of a sixth object: "To carry out any charitable object that is prescribed and that is related to any of the objects described in paragraphs 1 to 5."

Many health care providers are concerned that the role of CCACs will change into placement management and case management activities in service areas in which CCACs are not currently involved; that they will become the first point of contact for a broader array of services, without consideration to the systems already in place, such as in the case of the addiction treatment system. It is the view of Addictions Ontario that a good therapeutic relationship leading to positive recovery outcomes is established at the very earliest contact with the client, including screening, scheduling and assessment processes, and that the CCAC resources and organization are not a clinically appropriate mechanism.

In conclusion, our above comments are made within the context of our support for LHINs. However, we believe that the pragmatic issues of the LHIN boundaries, as well as issues related to procedural fairness, openness and respectful dialogue, should be acknowledged as part of the language and intent of Bill 36. Thank you.

The Chair: Thank you. There are about four minutes left and we'll allow some questions.

Mr. Ted Arnott (Waterloo-Wellington): Thank you very much for your interesting presentation. As I understand it, the LHINs, assuming this bill passes, will be empowered to make local health resource allocation decisions. As you pointed out, in some cases perhaps a LHIN might be deciding to transfer resources from a

hospital, let's say, to put more money into home care, if that's needed in the local community. But you've talked about the appeal issue and you've said that if indeed an appeal is launched on one of these decisions, there should be a requirement for the LHIN to at least engage the parties in some meaningful discussion so as to acquire additional information. I would certainly agree with that.

Yesterday we heard from one of the groups, and I forget which one it was, that said it doesn't make sense, if you're going to appeal a LHIN decision, to appeal right back to the same people who made the decision. Would you agree with that, that there needs to be some alternative organization set up—an appeals board, I guess you'd call it—to deal with these kinds of appeals?

Ms. Hardman: I would certainly agree with that. I think they're quite right in saying that you're appealing back to the organization that has already made the decision. So an appeals board would make sense.

Mr. Wilbee: Further to that, Mr. Arnott, we are also suggesting that there needs to be some provision for discussion prior to that. There need to be some checks or controls there if in fact the LHIN was unhappy with the service provider. We'd want to see some kind of mechanism that is resolved before a decision is made, but not in any way negating the ability to appeal to an arbitrator.

Ms. Shelley Martel (Nickel Belt): Thank you for being here. Further to that, you'd probably want some kind of provision whereby the public could have some say in where the LHIN is going. There's no provision right now for any kind of input from the public—consumers, patients etc.—when the LHIN makes a decision to integrate a service, end a service, consolidate services etc. Any discussion happens essentially with the service provider after the fact, as you pointed out.

I want to ask you about the CCACs, though, because it is very clear that the CCACs are angling to have a greater role in the provision of service. That came through yesterday in a presentation that was made to us by the Association of Community Care Access Centres, but also I saw a document that they produced last summer that talked about a greater case management role. Tell the committee what your concerns would be—you've outlined them briefly—because I've heard concerns like this before from other addiction agencies closer to my home, which is in northeastern Ontario, that they're not really interested in seeing the CCAC have a greater role in case management. Do you want to flesh that out for us?

Ms. Hardman: Sure. At this point, the CCACs really have no interface whatsoever with the addiction treatment system. It's not a system that they know. We have a very well orchestrated system in regard to referral and intake and assessment and that sort of thing. So to have an organization take on that piece when they really don't have any knowledge of it at this point would probably just complicate the system more, and I think also it would have a negative impact on the clientele. As we said, on the first point of contact we start forming our relationship with people. Also, often these people are in severe crisis and really are needing assistance immediately. So to kind

of complicate that mechanism or put another barrier, another wall up there for them, I think would be detrimental to them. I don't know if Jeff has something to add.

0920

Mr. Wilbee: No, I think you covered it. The essence is that you have to deal with people as they present. That doesn't mean to say that somewhere down the line—that is not to take away the good work that CCACs do. I think we would add, though, that we feel this is a specialized area. First of all, good assessment is not just the tools that are used, but that rapport that is built very quickly with skilled counsellors in this particular specialized area of additions.

Ms. Wynne: Just on that point, I think it's important—as recently as yesterday I spoke to the minister, and his vision of what the LHINs are going to do and what is laid out in this legislation is that they're going to have a coordinating and planning function, and I think that's critical. We've had district health councils that—somebody described them yesterday as bears without teeth or something. There was the planning function but there was no way to implement the plans. So what we envision the LHINs doing is coordinating and planning and figuring out where the gaps are and then moving to fill those gaps. So it's not a consolidation of services that's envisioned, but it's a coordination of services. Integration doesn't mean consolidation. I think we have to bear that in mind.

Thank you very much for your presentation. There are some very interesting points. On the issue of the pre-decision negotiation mechanism, I just wanted to ask you about the language that is in the object. It's part II, section 5 of the bill, clause (c): "to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation." It seems to me that it's in that planning function that the entities and the public will be engaged. I guess as a member of the government and as a citizen, I'm putting my eggs in that basket in terms of the rational process that the LHIN will engage in. Can you just speak to that section and how you might change it or add to it or whether it suffices?

Mr. Wilbee: I'm not sure whether it suffices or not. I think that's part of the debate that goes on here.

Again, this is dealing with language and I think we're concerned about, what does it mean to be community, what is that kind of consultation, where will the input be? One of our concerns, of course, is even around the advisory. Do you want the language to restrict the broad experience that we have? In trying to answer that, we even have concerns around the terms of only those professions that are named under the regulatory act. If that's to be legislated, then in fact we would restrict a wealth of information that would assist that planning. So I think that we're concerned around the language: What does community mean, what is that consultation, who are the experts who should be spoken to?

Ms. Wynne: I understand. Actually someone made the point yesterday about that advisory committee. So thank you very much.

The Chair: Thank you very much for your presentation.

ONEIDA NATION OF THE THAMES

The Chair: The next presentation will be from the Oneida Nation of the Thames, Chief Randall Phillips. Good morning, Chief.

Chief Randall Phillips: Good morning, Mr. Chair. How are you?

The Chair: Very well, thanks.

You can start any time, sir.

Chief Phillips: Good morning, members. It's an honour to be here in front of you today. I have a prepared text and I've made copies of it so it will be available for you.

The Chair: They are distributing it to us.

Chief Phillips: I hope that all members are in good health and spirit. I would like to thank you for the opportunity to speak to you here today. As the elected Chief of the Oneida Settlement, it is nice to welcome you to traditional Iroquoian hunting territory. My name is Randall Phillips and I am a member of the Bear clan of the Oneida Nation of the Thames Settlement.

I wish to take this opportunity to inform the members that this submission is presented in my capacity as an elected Chief of the Oneida Nation of the Thames First Nation community. This system of elected representation and governance through the Indian Act was imposed on our community in 1934. I make this distinction to recognize the legitimate role and responsibility of the clan mothers and titleholders of the Oneida Nation to deal with nation issues and to provide reassurance that I'm not here to represent those nation interests. Rather, I make this presentation as a duly authorized representative of the Oneida Nation of the Thames First Nation settlement, as recognized under current federal legislation.

I wish to make the following comments regarding Bill 36, An Act to provide for the integration of the local system for the delivery of health services, and the creation of local health integration networks.

As that recognized representative, it is also, in part, my responsibility to ensure that the rights of the Oneida people, whether they be treaty or aboriginally based, are protected against any federal or provincial encroachment through legislative or other means. It is, and has always been, our assertion that the governments must recognize health as an existing aboriginal and treaty right. Based on that assertion, it is my further responsibility to ensure that any service or program, health or otherwise, that is related to or is a consequence of this right is also protected. There is no difference if that service is delivered through federal or provincial sources. It is in that sense of protection and responsibility that the following comments are made. I'd also like to say that, given the short

amount of time, we won't be able to address all the concerns we have.

Bill 36 is designed specially to transfer the decision-making responsibility from the Minister of Health and Long-Term Care into the hands of a government-appointed local board of directors. This board of directors will have the authority to determine what health service will be available, when it will be available and who will deliver that service. This authority will be confirmed and exercised via the financial controls available to the LHIN boards provided through the legislation. This transfer will formally recognize the role of the LHIN boards in establishing local health priorities and the allocation of resources to address those priorities. Although the minister may still intervene if necessary, the responsibility to implement change on the access to and availability of health services at the local level lies solely with each of the 14 regionally based LHIN boards. It is this transfer of responsibility, with seemingly no regard for First Nations, that I wish to address.

In the spring of 2005, I was made aware of a presentation that was made by Barbara Hall, a member of the health transition team, to the Health/Social Advisory Board of the Association of Iroquois and Allied Indians. The AIAI consists of eight First Nations communities and is recognized as a regional organization by the federal government. Oneida is one of those eight communities. H/SAB is made up of various health program and social program directors at the community level. It is H/SAB's responsibility to review and bring forward issues to the AIAI chiefs for information and direction.

The H/SAB members raised some initial concerns with the LHIN presentation. Subsequently, these concerns were raised by the AIAI health director to the health coordination unit at the Chiefs of Ontario Office. Representatives of the Chiefs of Ontario Office then met with the minister to discuss these concerns. Initially, the minister outright objected to all the recommendations brought forward by the Chiefs of Ontario Office. Upon further reflection, the minister did agree to establish a First Nations task force to identify the concerns and real/potential impact on First Nations and First Nations health programs with respect to these LHINs. The First Nations task force included representatives from First Nations political organizations, including political and technical representation. I was appointed as a political representative for the AIAI chiefs' council. Janet Brant-Nelles, from the Mohawks of the Bay of Quinte, was appointed as the technical representative. The task force began its review of the available information on LHINs in September 2005. We were given a two-month time frame to report back to the minister. That report was delivered to the minister at the end of November.

I just want to take time to acknowledge the work of those task force members in dealing with that report. There was an awful lot of information that we had to cover in a very short period of time, and I think the report reflected that.

I would like to talk a little bit about the process. With regard to process, I would suggest that the actions taken

by the Ministry of Health and Long-Term Care in the early stages were not designed to specifically address First Nations health concerns nor the integration of First Nations health services and programs. First Nations were regarded as mere stakeholders in this process. This stakeholder status directly conflicts with the duty of the crown in dealing with First Nations with respect to consultation. Recent Supreme Court decisions confirm this fact. Given the unique fiscal arrangements that exist between First Nations communities and the crown regarding the delivery of health services, direct consultation would have seemed prudent.

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This made-in-Ontario health reform was taking place in the midst of ongoing discussions relating to a first ministers' meeting on aboriginal issues, which included substantial investments and discussions in the area of health. The position put forward by First Nations at the first ministers' meeting was captured in a document entitled First Nations Blueprint to Health. This blueprint called for a specific First Nations stream; a process to discuss these very issues and concerns, like the creation of new health institutions like LHINs and how they would impact on First Nations health services. The first ministers' meeting was about inclusion of First Nations, not exclusion.

In reviewing this government's own documents with respect to aboriginal policy, I have found further evidence that First Nations are not treated in the government-to-government manner that the policy outlines. This lack of direct consultation with the First Nations of Ontario on this issue is a breach of that policy and totally disregards our involvement in planning for our future health needs. The absence of direct consultations with First Nations must be addressed.

First Nations health services are provided through a complex process of funding arrangements, designed to deliver a variety of health services in a culturally appropriate manner and environment. Responsibility for the primary health care needs of First Nations people rests with the federal government. Recognizing the right to determine the best method to address the health needs of First Nations is formally expressed through contribution agreements with the federal government. These contribution agreements are administered by Health Canada and the First Nations and Inuit health branch.

In other instances, health care services for First Nations are funded by the provincial government. The aboriginal healing and wellness strategy is an example of funding through contributions of several provincial governments. This strategy is designed to provide funds for various aboriginal health-related programs. This funding can either enhance an existing service or be directed towards addressing another need. Although the minister has provided some assurance that the funding for the AHWS will not be subject to the LHINs, we anticipate that it is temporary, as there is only a five-year contribution agreement to deal with LHINs.

In yet other circumstances, the province receives federal funding which includes First Nations populations

and must ensure access to these services. It is difficult to determine how these resources are allocated to improve access and availability of existing health services to benefit all First Nations people.

Given these complexities, it is prudent, if not necessary, to discuss the impact of creating new decision-making bodies that would be directly responsible for the allocation of health resources without specifically including a process that would include First Nations. The failure to address the unique funding arrangements of First Nations health programs and services must be addressed.

The legislation makes reference to First Nations only in the preamble, with this statement: "The people of Ontario and their government...."

"(e) recognize the role of First Nations and aboriginal peoples in the planning and delivery of health services in their communities...."

This statement clearly identifies that First Nations should be included. However, the evidence with respect to exclusion is contained in the body of the legislation. Nowhere in the legislation are First Nations mentioned. First Nations health programs and services are not mentioned. There is no requirement for LHIN boards to consider First Nations. There is no requirement for the minister to deal with First Nations issues. There is no mention of any mechanism that would directly involve First Nations or include their participation. Yet the legislative preamble recognizes the role in planning and delivery. It should be removed, and the preamble should only contain a non-derogation clause with respect to the recognition of aboriginal and treaty rights.

In order for the proper consultation to occur with First Nations regarding the impact of this change in the delivery of health services, I would suggest that a separate First Nations process be established. In the interim, I would support the following legislative placeholders. The exact wording could be drafted by our technicians.

(1) "First Nations health programs and services are exempt from this legislation."

To ensure that existing and future First Nations health programs and services remain available to meet the health needs of the people and are not threatened by LHINs in the future, the legislation should clearly provide an exemption for First Nations health programs and services.

(2) "The minister can enter into specific agreements with First Nations health providers."

To ensure that First Nations people are not excluded from any increase or enhancement of LHIN-sponsored health services by the Ontario government, the minister should retain the ability to enter into specific funding agreements with First Nations representatives. This provision is also included in other provincial legislation regarding health integration.

(3) "LHINs must identify a separate process to include First Nations health providers."

To ensure that First Nations are included in local planning of health services and other public health concerns, the legislation must direct the LHINs boards to develop mechanisms to include First Nations.

(4) "LHINs can enter into specific agreements with First Nations health providers."

To support the development or enhancement of the integration of First Nations health services with the LHINs, the legislation should recognize a mechanism to provide resources to a First Nations health service provider.

The legislation was presented to the House without addressing any of these concerns. I know we had talked and sent a letter to the minister on these. It's my experience in dealing with these legislative processes that it becomes significantly more difficult to make these kinds of changes that are being introduced.

Now, I'm here to convince the members to ensure that the legislation presented for your review will address our concerns before it is returned to the House for third reading and final approval. Committee members must also uphold the honour of the crown.

In closing, I've got two more recommendations for committee members' consideration:

(1) I would further recommend that committee members endorse the continuation of the LHINs First Nations task force. The report of the impact of LHINs on First Nations health services outlines many concerns that should be the subject of a separate process. The First Nations task force is inclusive of all aboriginal health service providers and represents the needs of First Nations people regardless of residency. Although the final decision will rest with the minister, the stand committee would recognize the complexities of First Nations health service systems and the need for further research.

(2) For the committee members' further consideration, I am currently involved with another ministry that also produced legislation that will have a direct impact on First Nations: Bill 210, An Act to amend the Children and Family Services Act. These amendments will impact on the many First Nations specific provisions contained within the Child and Family Services Act. Minister Mary Anne Chambers agreed that we do have a vested interest in the act and that the amendments would indeed have an impact on First Nations. The minister agreed that a separate process be established to examine the concerns associated with the act and the amendments. The minister committed to ongoing dialogue to this issue with the chiefs committee on child welfare.

I would suggest that this process, which recognizes and creates a specific First Nations stream, could also be utilized in this review. The First Nations task force is well positioned to meet with ministry officials to participate in a specific process. Without this, First Nations are once again denied our constitutionally protected rights with regard to consultation.

I thank you for time, Chair. I'm available for any comments.

The Chair: Thank you, Chief of the Oneida Nation of the Thames. There is no time. In fact, you went over the

allotted time, but we thank you for your presentation. Thanks for coming and talking to us.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 4727

The Chair: The next presentation is from the Canadian Union of Public Employees, Local 4727, and Huron Perth Healthcare Alliance.

Ms. Deb Hirdes: Good morning. My name is Deb Hirdes. I'm president of CUPE Local 4727 of the Huron-Perth Healthcare Alliance. I represent 500 service and clerical workers at Stratford General Hospital, St. Marys Memorial Hospital, Clinton Public Hospital and Seaforth Community Hospital.

Once again, the Ontario government wants to transform health care and certain social services, this time by creating local health integration networks. Fourteen LHINs have been established in the past year to plan, integrate and fund hospitals, nursing homes, homes for the aged, home care, addiction, child treatment, community support and mental health services.

The LHINs are local in name only. Bill 36 would grant little real power to local communities and providers to make decisions. The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

What follows is an outline of these problems and their likely consequences. We would also like to suggest some very different reforms that could actually improve health care and social services in Ontario.

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LHINs cover a vast and very diverse area. The LHINs' boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent communities of interest. As a result, they lack political coherence. The southwest LHIN, where I live, runs approximately from St. Thomas up to Tobermory and just west of London to this side of Kitchener-Waterloo. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

LHIN boards will be responsible to the provincial government rather than to local communities. Recently, however, the government has found a way to blunt the criticism of underfunding and privatization. The key is to replace the community boards with government-controlled boards. This is the model for the LHINs. This was an experiment taken at the community care access centres and it suggests that this is a very poor model for the LHINs to follow.

CCACs were taken over by the provincial government in 2001. Their funding was flatlined for years and home care services were cut back dramatically. Tens of

thousands of frail elderly and disabled lost their home support services. In total, the effect was a reduction of 30% of hours available for patient service from 2001 to 2003. The problems with competitive bidding became so severe that the government has suspended the bidding process for some time.

Despite these problems, the Ontario government now is talking of extending the purchaser/provider split to other areas of health care. There are no provisions in the bill which ensure, require or even encourage the LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. Indeed, these bodies would now have legal authority to privatize large parts of our health care system. Government-controlled regional agencies are a poor model for health care and social service reform, yet this is what we are facing.

The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation. What service will the LHIN provide in each area of the LHIN? Smaller communities may be the first to see their services integrated into other communities.

These serious problems suggest another direction must be investigated. We need to provide for the democratic election of LHIN directors by all residents in the LHIN geographic area. There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. We need a requirement that each LHIN must establish a health sector employee advisory committee, made up of union representatives and representatives of non-unionized employees. We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public. We need to ensure the right to seek reconsideration and full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decision or regulation.

Bill 36 gives LHINs and the government a wide range of tools to restructure public health care organizations. LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or transfer of a service. The bill gives the minister even more powers to order integrations directly. Specifically, the minister may order a not-for-profit health service provider to cease operating, amalgamate or transfer all of its operations. For-profit providers are exempted from this threat. The bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of non-clinical service, so this definition may be a matter of considerable controversy.

The government refers to this restructuring as integration, stating that the goal is the creation of seamless care and a true health care system; but this is misleading. The LHINs restructuring will not unite hospitals, homes, doctors, laboratories, home care providers

and clinics as it has in other provinces. Plans to spin off to for-profit corporations private clinics and regionally based support service providers will mean more fragmentation and less integration of our health care system.

A key goal of this reform is to constrain costs by integrating services, but this also raises questions about cutting services to local communities. The government plan is to regionalize hospital support services.

With government support, 14 hospitals in the greater Toronto area plan to regionalize supply chain and office services by turning work over to another new organization, Hospital Business Services. This organization would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations, and then sever roughly 20% to 25% of these employees. This is a major change that may have far-ranging consequences for workers and local communities, and more such plans are in the works.

Like so much of restructuring, these moves will have a major negative impact on hospital support workers, but they will certainly not create seamless care for the patients. Instead, they will create more employers and bring more for-profit corporations into health care. In many respects, it will create more fragmentation.

In April 2005, the health minister publicly called for the centralization of hospital surgeries: "We don't need to do hip and knee surgeries in 57 different hospitals." Instead, he suggested that about 20, which is a 60% cut, might be appropriate. The minister went on to indicate that hospital specialization is the order of the day: "Each hospital in Ontario will be given an opportunity to celebrate a very special mission ... but not necessarily operating with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travel for health care services.

The government has also begun to move surgeries right out of hospitals and place them in clinics. But the creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to as they tend to their health care needs. It also raises the possibility of the establishment of for-profit surgical clinics.

A better solution would be to create surgical clinics in the facilities and organizations in which they are already invested. Hospitals have the infrastructure needed to support these surgical clinics. Local services are under threat; we cannot let local hospitals and the communities they service be shut out.

In the communities that I represent, the number of patient beds available for admission to hospital has been drastically reduced in the last number of years. This has resulted in the holding of patients in the emergency room. This in turn severely limits the space available for true emergency patients. Housekeeping has been reduced. Only clinical areas of the hospital are routinely cleaned. Food is no longer prepared on-site. Staffing is at a minimum, and we are constantly struggling to meet the benchmarks set by this government. Under these LHINs, where will my local hospital be next?

LHINs are to be given powers to fund and manage health care and social services. This raises the question of whether service levels will vary by LHIN. Currently, we have no sense from the government of how far it will allow regional variation to proceed, yet the consequences could be quite significant. Consolidation of services doesn't necessarily mean cost savings.

The LHIN reform does not directly deal with the undisputed real health care cost drivers: soaring costs for drugs and equipment supplied by transnational corporations. Instead, health care workers and patients will bear the brunt.

Integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability will make it easier for the government to implement these threats. We need fundamental change:

—Provide in the bill that the cabinet, the minister and LHINs may only exercise their powers in the public interest.

—Provide in the bill that the LHINs, the minister and the cabinet cannot order or direct integration, nor approve or disapprove integration. The power that LHINs have to withhold funding is power enough to encourage consolidation. The LHIN, minister and cabinet should not have the right to transform the health care system unilaterally; otherwise there is no reality to the claim that we are enhancing local decision-making and no point in retaining provider governance structures.

—Provide in the bill that the LHIN, ministerial or cabinet power to withhold funding to force integration only be exercised where necessary in the public interest and where integrated services remain publicly delivered on a not-for-profit basis.

—Provide in the bill that transportation subsidies will be paid by LHINs if the required service is no longer provided in a given community. No purpose is served if integration creates new costs for residents.

—Provide in the bill that nothing in the legislation authorizes cabinet, the minister or LHINs to override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements.

This legislation allows for the establishment of private clinics and the expansion of private hospitals, even though a recent poll showed 89% of the people in this province are against privatization of public health care.

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Impact on bargaining units: The change in health care delivery contemplated in these reforms opens up possibilities of enormous changes in our bargaining units, collective agreements and collective bargaining for health care workers. We've been through many rounds of restructuring, and we're about to do it again. We want the protection in the Public Sector Labour Relations Transition Act in Bill 36 so that the act, which is also in effect, will be kept in effect when you're transferring our people. We want to remove from the bill the authority to exempt application of this act, and we want to provide

that nothing in Bill 36 but the application of this act can have the effect of overriding our negotiated security provisions.

That ends my formal presentation today. But what I would like to say now on a personal note is that even though I stand here representing health care workers, on a much larger scale, I'm a resident of this province. I have three daughters, parents, grandparents and a large extended family in this province. I live in what is termed a rural area and I am concerned that the appropriate health care for my family will not be available to them. I am concerned that they will have to travel many kilometres for care or that I will be driving under circumstances not ideal, because under the direction of the LHINs board, my local hospital does not offer services to my community, or worse, they will offer these services outside of my hospital and I will have to pay for them.

While I understand the problems in health care, I urge the government to slow down. Let the public really have a say in something that will have a huge effect on all of us. To hold these public meetings after this bill has already passed second reading, when Bill 36 will most likely pass into law by the beginning of March, is shameful. The fact that this bill does not specifically say that our health care will not be privatized is a huge issue for all the residents of this province. To only hold four days of public hearings for an issue of this magnitude should be unacceptable to all of us in this province. Thank you.

The Chair: There is no time for questions, but thank you for your presentation. The hearings, by the way, are seven days. It's four in Toronto and in London, Ottawa and—

Ms. Hirdes: So that's been changed not too long ago.

The Chair: Yes, because we responded to the request. We had lots of requests and we had agreed in principle to do that, and we have done so. But thank you for the presentation. It's a pleasure to be here in London and vicinity.

Welcome the local MPP from London, Khalil Ramal, joining us. Can we have the next presentation—

Ms. Wynne: And Maria Van Bommel.

The Chair: Oh, I'm sorry, Maria. She was here from the beginning. So two of our London representatives.

AAMJIWNAANG FIRST NATION

The Chair: The next presentation is Aamjiwnaang First Nation. Thank you for making the presentation. Welcome. You can start anytime, sir. There are 15 minutes total. You may want to introduce your colleagues and friends.

Mr. James Maness: My name is James Maness. I'm a councillor from the Aamjiwnaang First Nation. My portfolio is health. To my left is Darren Henry. He is a councillor. With us and on my right is Stacey Phillips, who will be making the presentation.

I'd just like to thank you on behalf of the Aamjiwnaang First Nations. A big meegwetch to give us time to declare our position and our concerns to the committee.

I'll turn this over to Stacey.

Mr. Stacey Phillips: Good morning and meegwetch. Thank you for giving us this time. Any comments that are contained in this submission should not be interpreted as consultation with Aamjiwnaang or on behalf of any other First Nation.

Aamjiwnaang has a unique nation-to-nation relationship with Canada. We are opposed to Canada's yielding of this relationship by assuming that we support the downloading of their fiduciary responsibilities for First Nation health to the provincial and local health integration network.

Aamjiwnaang opposes having to address our First Nation health issues with these local boards. Canada is placing First Nation decision-making authority as it relates to health with entities that have no experience in funding First Nation health. These boards also have no understanding of or focus on our priorities pertaining to First Nation health, thus relenting their fiduciary duty and responsibilities to First Nations people.

It is suggested that decisions regarding Aamjiwnaang's First Nation health will not be made by the First Nations in Canada or by the province. Individuals selected for the local health integration network boards from surrounding communities and municipalities will make these decisions. This will completely erase First Nation health jurisdiction.

There is always concern about strained relationships with surrounding communities and systematic racism impacting First Nation priority in terms of allocating health services and health resources. First Nations consultation did not occur to ensure that proper checks and balances are in place to protect Aamjiwnaang's right to self-government, our unique nation-to-nation relationship and Canada's fiduciary responsibility to the First Nation peoples of Canada.

Our provincial tribal organizations, such as the Union of Ontario Indians, will now be addressing health-related issues as they arise with as many as 14 different LHIN boards instead of Health Canada or the Ministry of Health. This is a real efficiency issue, as our PTO leadership is involved in addressing First Nations issues outside the health sector as well.

LHIN legislation bureaucracies will lead to First Nations reporting on health funding not to Canada but to these boards. This is clearly in violation of our authority and jurisdiction over First Nations health. Furthermore, Aamjiwnaang has concerns with privacy issues regarding LHIN data collection on First Nation communities.

Finally, I would like to reiterate the shift of fundamental issues regarding relations with Aamjiwnaang and Canada. The issue of fiduciary relations with First Nations health will cease to exist, as the bureaucracies created will assume this responsibility, completely erasing First Nation jurisdiction for health. This is a huge price for First Nations to pay, as our funds can now supplement the provincial and the LHIN system.

On behalf of Aamjiwnaang, I would like again to say meegwetch for this opportunity to declare our opposition to Bill 36, the Local Health System Integration Act, 2006.

Mr. Maness: Again; we'd like to thank you very much. Meegwetch. A copy of the presentation has been given to the clerk.

The Chair: Yes, we all have a copy, and we'll be happy to ask some questions or make some statements. I'll start with Madam Martel. You have about a minute and a half each.

Ms. Martel: I heard an earlier presentation expressing very similar concerns, and concerns yesterday in Toronto as well about the lack of consultation with First Nations with respect to the bill. We heard it particularly in the context of the blueprint that was produced between the first ministers, which set out a process of consultation that was completely set aside with respect to this particular bill, and also the context whereby the government announced this summer that there would be a new relationship with First Nations and yet, despite this announcement by the government, despite the blueprint, there was absolutely no consultation with First Nations about the bill. We have heard that message very clearly, and I regret that that was the position taken by the government with respect to this bill, most particularly in light of the announcement the government made about a new relationship just this summer, while the bill was obviously being drafted.

What would you like to see now with respect to this bill? I assume you would like it to be set aside and have no impact on First Nations, and that the government work with you to develop a real process around problems facing aboriginal people with respect to health care.

Mr. Phillips: I completely agree, and I think it was stated by the Oneida First Nation as well that there be a separate process. It's very complex because, as you know, the province has agreements with Health Canada such that there are organizations that deliver health care services, and money is put in by both the provincial and federal governments. The aboriginal healing and wellness strategy is one example. I think one of the questions is, how much is this going to impact and where is this going to impact First Nations in terms of health services? We're uncertain of that in terms of how to prepare and how this legislation is going to affect our First Nation communities, both on and off reserve.

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The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I just wanted to go back to a comment you made, and that Randall Phillips of Oneida made earlier; that is, that a task force report was commissioned by the minister before the legislation was introduced. So that task force report has come to the minister. I believe there was also one from the Metis. Can you tell us at this point what the major recommendation in that task force report is? I understand also that those recommendations are being reviewed and the minister is in conversation with you as a result of that task force report. Is that true?

Mr. Phillips: I'm not a member of that task force, so I would hate to comment on some of their strong recommendations. That question should have been directed to

the Chief from Oneida, who was actually a member on that task force.

Ms. Wynne: Yes, I wanted to ask that question. I was trying to sneak it in here because I couldn't ask Mr. Phillips.

Mr. Phillips: I wasn't a part of that task force; I just reviewed their document. I do think some of their concerns have already been expressed throughout the seven days, or however many you're into. I reviewed that document. I didn't want to reiterate many of their concerns, because their concerns affect all areas, not only health. But I think a lot of it is lack of consultation in terms of how this is going to impact First Nations.

Ms. Wynne: My understanding is that that document is being reviewed by the minister and that he is in conversation with the people from the First Nations who wrote that document. Our hope is that there will be a resolution of some of the issues you've raised.

The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for your clear and concise presentation; it's very helpful. We've heard a lot of concern from First Nations organizations about the lack of consultation prior to the introduction of Bill 36, and you've identified that as a huge issue. What would have been an appropriate consultation exercise, in your opinion, prior to the introduction of a bill of this nature?

Mr. Phillips: One of the things I've heard, not only in the First Nation communities but in general, even in the Sarnia-Lambton area, is the lack of information regarding the LHINs and how they're going to impact our communities. I think the biggest concern we have is how it's going to impact us at the local level.

I think one of the challenges we have right now is in long-term-care services. We haven't been able to access long-term-care facilities on reserve, and we've always struggled to do that. We need those services right now, because we have a lot of senior people who have their culture and their language as their mother-tongue, and there are no appropriate services on reserve at this point to accommodate those needs. That's one area I can think of right now. First Nations have had a difficult time securing long-term-care services on reserve. We need them now, not 10 years from now, because the people who have their language and their culture are at that age and in those facilities with no programming geared to their needs.

The Chair: Thank you very much for your presentation. Have a nice day. Thank you for coming. Meegwetich.

WATERLOO REGIONAL LABOUR COUNCIL

The Chair: The next presentation is from the Waterloo Regional Labour Council. Rick Moffitt. We already have some material from you, which we are distributing. You may start any time.

Mr. Rick Moffitt: The Waterloo Regional Labour Council represents 26,000 union members in our um-

brella organization, affiliated through their individual locals. The Waterloo Regional Labour Council represents blue-collar and white-collar workers in both the public and private sectors. We are active in all aspects of the economic, social and political life of our community, and we work with our community partners to maintain and strengthen health care and the public education system and to protect our social programs.

We are pleased to have an opportunity to address this committee, and look forward to sharing our concerns about the legislation proposed in Bill 36 and to making recommendations for change that will make it more palatable both to the public, which is accessing health care, and to those who work in health care on the front lines.

Our first concern, frankly, has to do with the manner in which this proposed legislation has been introduced and the procedural decisions that have been made regarding the debate in the Legislature, as well as the opportunity that members of the public have had or will have to comment on the proposed legislation. In our view, it is unacceptable that a proposed government bill that will have such a far-reaching effect should not be granted far more debate time in the Legislature. When one considers that the current government never sought nor received a mandate to create a new system of health care delivery in the last election, all legislation ought to be put on hold.

Adequate public consultation should be obtained prior to second reading, not after. Such consultations need to take place in all parts of the province, and not be confined to four cities in a compressed time period, holding hearings, as I understand now, over a seven-day period. At an absolute minimum, hearings should be held in each of the 14 proposed LHIN catchment areas. Hearings should be held during hours in which members of the public are available to attend, not just during business hours. So our first recommendation is that the standing committee on social policy should hold public hearings and consultations in all proposed catchment areas during hours in which members of the public ought reasonably to be able to attend. Such meetings should be held over a two-day period and in a format that both explains the proposed changes to current practices and allows for feedback from the parties attending.

A reading of the proposed legislation in Bill 36 suggests that there will be both reduced community control over health care services and reduced government accountability. Neither is in the best interests of the citizens of the province. The LHIN structure puts up significant barriers to local control over health care. In fact, it centralizes power in the Ministry of Health and in cabinet, taking control away from local, community-based providers. It creates a new layer of bureaucracy that is accountable not to local communities, which they aim to serve, but to the Ministry of Health. A board appointed by the Minister of Health will govern LHINs, and it will be accountable to the Minister of Health. It will not be accountable to the community.

This is a very different model than we currently have, where the government does not, for instance, appoint

hospital board members. In the past 10 years, hospital boards across this province have repeatedly held the government accountable for funding cuts and funding shortfalls, and they have been very successful in restoring funding to local communities.

I live in Cambridge. Cambridge has a hospital that was cut out of the last round of funding announcements by this government and by the Ministry of Health. Pressure from our local community—from the hospital, from community leaders—forced the government to restore a funding promise that had been cut. It's clear that Bill 36 proposes to end the possibility of this type of community action.

It is clear that transferring fixed amounts of funding to a LHIN and having them announce funding decisions will provide a level of insulation for the government. The government will control the LHIN, but the LHIN will actually implement decisions on privatization and the amalgamation of services.

I must say, as a school teacher and as somebody who lived through a whole bunch of cutbacks in education, watched powers being taken away from school boards and watched the former government use school boards to take the flack for funding cuts and decisions they made, it's really disturbing for me to see this government heading in the same direction.

The large, socially diverse area covered by a LHIN suggests there will inevitably be conflict over resource allocation. How will a community fight back when services in that community are amalgamated with those in another community? Whom will they launch complaints with over service cutbacks and the introduction of privatization?

This leads to our second recommendation: There must be democratic elections at the local level for LHIN board members and directors, based on their geographical areas. There must be public hearings on the proposed boundaries for all LHINs, to ensure that they do in fact constitute a local/regional geographic service area. There must be a mechanism for local communities to appeal decisions, including the use of arbitration and the courts.

Again, I want to point out some parallels to what the former government did. We had some 60-odd boards of education in the province, and they reduced those to 31. This is much like what is being done here. We are talking about 14 service areas across the province—service areas that are as big as countries in Europe. To my mind, it is really absurd to think about this. It is unacceptable that someone living in Cambridge could have their parents put into a long-term health care facility in Orangeville because Orangeville, in a competitive bidding process, somehow came up with the best rate for long-term care, or that somebody who needs a hip replacement and lives in Orangeville has to come down to Kitchener to get a hip replacement, because the Kitchener hospital wins a competitive bidding war to do hip surgery; or that someone who has a heart problem, perhaps in Guelph, has to travel to another community. It's really unacceptable.

The proposed legislation will provide reduced access to care and increased service integration. Many citizens view terms such as “increased service integration” as the language of privatization, and view this as the portal for private participation in our health care system.

1010

It is clear to those who understand the language of government that increased integration is an Orwellian synonym for service cuts. Simply put, service cuts mean cutting back on the number of hospitals offering particular services.

The minister himself has been quoted in the *Toronto Star* on numerous occasions. At one point, he suggested a cut of 60% of the hospitals that perform hip and knee surgery, meaning people will have to travel those longer distances. It means that we will see a trend of moving services out of hospitals and into clinics. We now have eye clinics in this province. We have heart clinics, hernia clinics and others operating outside of the facilities built to cater to the overall needs of the community, i.e., our hospitals. This means a duplication of administrative and support services that are already available in the very hospitals that the minister is proposing to have procedures removed from.

Patients will need to travel to multiple sites and see multiple medical professionals. This proposed legislation will fragment health care as patients run from provider to provider to service their multiple needs.

It is clear that the hospital consolidations that the previous Conservative government implemented over the protests of the community did not save money and, frankly, there is no reason to believe that these integrations and consolidations will save money either unless they are accompanied by significant cuts to overall service.

Our third recommendation, then, is that provisions be placed in the legislation that allow for the integration of services only when there is a demonstrable benefit to public interest, and that the public interest cannot be met solely by a financial savings.

“Public interest” should also be defined to include a provision that includes a public, not-for-profit health care delivery model. Private for-profit diagnostic and surgical clinics should not and cannot be a part any LHIN.

In conclusion, the Waterloo Regional Labour Council has serious misgivings about the proposed legislation. I believe that we have been clear in these recommendations. Our final comments must address the potential use of P3 or alternative financial procurements to fund capital costs incurred by LHINs. Let me be clear: Our council is totally and adamantly opposed to these financing arrangements, which are clearly not in the public interest.

We have viewed with much horror the unfolding facts about the P3 financing of the new Osler hospital in Brampton. The Liberal government set out criteria for the use of P3 financing. They said that it had to save money. They said that it must enable the public sector to expand without incurring risk and that it must attract private

capital to be used for the public good. This is clearly not the case in the Osler hospital construction. Details about the contract are now making their way out to the public. The contract signed by the government agrees to set an interest payment for the mortgage on the facility at 2% more than the 10-year government of Ontario bond rate. So it cannot save money. It is impossible to save money when you've set an interest rate at 2% higher than the rate at which you, this government, can borrow money in the first place.

Second, the Osler hospital contract contains an agreement to pay service fees to the consortium for arranging that same financing at an excessive rate of \$10 million, or 4% of the overall cost of the contract.

Finally, given that the government has already allowed the consortium to contract to provide administration, cleaning, food services and maintenance services, it is clear that there is no public interest being protected here. The increased costs associated with the mortgage means that the government could have built a facility 1.75 times the size of the hospital for the same money. Shame on the government for agreeing to use the taxpayers' hard-earned money this way. Shame on private companies for inducing them to do so.

Our final recommendation is that the commercialization of public services must not be facilitated by the use of P3 financing in any LHIN capital project.

The Chair: Thank you, Mr. Moffitt. There is less than two minutes; one minute each. We'll start with Ms. Wynne, please.

Ms. Wynne: Thank you for being here this morning. I want to pick up on your comment about the reduced community control. I'm a former public school trustee in Toronto—

Mr. Moffitt: I'm well aware.

Ms. Wynne: I know that there are now only 72 boards in the province, and I am here because I fought the amalgamations of the previous government tooth and nail for eight years.

Mr. Moffitt: And were supported by the ETFO union, of which I am a member.

Ms. Wynne: Exactly.

One of the things I want to say is that in putting these LHINs in place, we're putting in place a structure so that citizens actually will have more information. When you talk about activism and the ability to react to a plan of a government, right now, if somebody wants to know what the overall plan is for health care in their area, there's really nowhere to go. There's no public meeting, there's no opportunity to have that conversation.

With the LHIN in place, citizens will have more information, and my experience is that activism and ability to oppose or to approve is fed by information. I really think, as a former activist, as a current activist, that giving people more information, helping them understand what the plan is, where the gaps are, is going to make a more informed citizenry and is going to allow the government to be more accountable to community, and that's what this bill is about. I'm supporting it as a member of

the government because I believe it's going to be better for people and it's going to give people more information.

Mr. Moffitt: With all due respect, that didn't sound much like a question.

Ms. Wynne: Sorry, it was just a soapbox moment. I apologize.

The Chair: It's a question or a statement. One minute each, Mr. Arnott.

Mr. Arnott: If I have a minute, I'd like to give Mr. Moffitt a chance to respond to Ms. Wynne.

The Chair: Thank you, Ted.

Mr. Moffitt: I would very much like to respond. Given that you're suggesting that the government has such lofty ideals in introducing this legislation, perhaps you can explain to me why nobody in this province seems to know what a LHIN is unless they're an activist within a union that is fighting against it or they're somebody who represents a special interest. Quite frankly, this government has treated this whole proposal like they're growing mushrooms; i.e., in the dark, plenty of manure.

The Chair: Madam Martel.

Ms. Martel: Thank you for being here today. The legislation holds no provisions with respect to how the LHINs will meet with people, how there will be consultation. There's nothing in the legislation. It says that will be developed in the dark by regulation. It says that the LHINs are supposed to develop a health care plan based on the provincial health care plan. That hasn't been developed. We don't know who's part of that. There has been no consultation with the broader public community. That's being done in the dark. It's silent with respect to what the LHINs will do in terms of making decisions about integration. We do know that they don't have to go to the public when they decide to integrate a service or consolidate a service; the only discussion they have is with the service provider after the decision is made. Frankly, in terms of public input either into a plan or into decisions, there is none, zero, nada.

The LHINs are agents of the government. It's very clear in the legislation. My concern is, as you've already described, they will become the buffer between the government making decisions that are distasteful and the LHINs having to carry that out and them taking the flak on the local level.

I don't know if you want to add anything else with respect to what else you see in this bill.

Mr. Moffitt: I think it's pretty clear from the experience in England, where most of the structure for this program has been lifted from, that it has caused nothing but problems. Health care is not getting better. The largest hospital in London, England, went bankrupt just before Christmas. It was a hospital that was built with P3 funding and had all of the same bundling of contracts that is being done up in Osler; i.e., all of the services within the hospital. Now they find that they are in fact able to make their mortgage payments, clean the hospital and provide food; they just can't spend any money on health

care, because they don't have any money left when they finish doing that.

My fear is that that's what's going to happen with the LHINs when you bring the private sector in and when your first commitment is to deal with the financing of the Ministry of Health, not with the care of patients who need services.

The Chair: Thank you very much for your presentation and your answers. Have a nice day.

COUNTRY TERRACE

The Chair: We're moving to Country Terrace and Mary Raithby. Good morning. Thanks for coming.

Ms. Mary Raithby: Good morning. My name is Mary Raithby. I'm the executive director of Country Terrace, a 120-bed, licensed, not-for-profit nursing home in Komoka and the best long-term-care home in Middlesex Centre.

We are committed to helping meet London and Middlesex's long-term-care needs. We are proud of the job we do. We also recognize that we can increase our value to our community by continuing to provide access to provincially standardized and regulated core long-term-care services for our oldest and frailest citizens; developing new programs and services that respond to the area's needs; and providing a more seamless health care journey that provides people with the care they need, when they need it, in a setting that is most conducive to their need. This is why I'm here today.

Community engagement, local decision-making, service integration and the other key elements of Bill 36 provide a solid legislative framework to make this happen. Generally speaking, I am pleased to be included as a health service provider, and I am encouraged by the bill's vision. My 20 years of long-term-care experience, however, tempers this optimism with caution. Unless specific implications of Bill 36 are addressed, they will negatively impact the ability of Country Terrace to contribute effectively to the LHIN vision. I am pleased to have the opportunity to raise these issues and offer my solutions to the committee.

1020

I want to begin with three overarching observations.

My first observation is that I do not expect this committee to end up defining all of Bill 36's unknowns. I believe it is appropriate that this occur through a combination of improvements to Bill 36, the accompanying regulations, government policy and changes in other legislation. I hope instead that this committee will improve Bill 36's ability to foster a stable environment where Country Terrace can be an equal and confident partner in developing an integrated health care system.

My second observation is that Bill 36 does not appear to have fully contemplated its impact on long-term care. I am not surprised, given that we are often the exception to the rule of health care system planning. This exception stems from three facts: All homes deliver a provincially standardized and regulated program of care and services

within a standardized funding and accountability framework; this standardized program is delivered in over 600 homes across Ontario by a mix of not-for-profit, charitable, municipal and private providers; and, unlike other health care services, both the province and the residents fund long-term care. Residents in Komoka write the same cheque for this service as residents in London and Toronto. In return, they expect access to the same level of service.

My remarks today primarily focus on continuing our ability to deliver this core provincial program. Of all the things we can, or might, do in the future, this has the most value to our community.

My third observation is that it's difficult for me to comment on Bill 36 without reference to the pending new long-term-care homes act. This act will define how we operate as long-term-care homes within Bill 36's overall operating framework. I believe this has contextual relevance for you, as legislators, in your task today.

These two new pieces of legislation must be mutually supportive. This supportive relationship offers the best opportunity to resolve the major implications of Bill 36 on my home's core services. It all boils down to the fact that as a long-term-care provider my service is my beds. Let me explain.

The ministry issues a licence to Country Terrace, other not-for-profit, private and some charitable homes for the number of beds that we operate. The remaining charitable and municipal homes have ministry-approved beds. This mix of licensed and approved beds is the result of the fact that there are three separate acts currently governing operators.

I receive per diem, not global, operating funding directly tied to my licence. Homes with approved beds are funded on the same basis. In both cases, operating funding, and thus service, will adjust directly with any changes to the number of licensed or approved beds.

As a licensed operator, there is a second link between my licence and my service. My licence factored heavily in my bank's decision to lend Country Terrace mortgage money. Any reduction to my licensed beds, of course, impacts the collateral value of my licence and thus increases my risk in being able to continue as a provider.

In the new long-term-care homes act, it is clear that the minister will retain total control over beds. The government's consultation document on this new legislation contains a whole section on the treatment of licensed and approved beds. In retaining authority over beds, the minister will in fact also retain authority over long-term-care services.

This is, of course, inconsistent with the direction of Bill 36 to devolve service authority to LHINs. If this inconsistency is not resolved, Bill 36 will place service access equity and provider stability at risk.

I would now like to offer some solutions to mitigate this.

As currently written, the relevant parts of part IV, section 20, provide me with no assurance that my LHIN will fund all of the beds that the province licenses me for.

This uncertainty is cold comfort to the 120 Ontarians who call Country Terrace home, to say nothing of the 20 on my wait-list or those in my community who will need our services in the future.

You can remove this uncertainty with language changes that would require LHINs to fund homes consistent with their provincially licensed or provincially approved bed capacity. Specifically, part IV, subsection 20(1) should be amended by adding "where a health service provider is a long-term-care home, the service accountability agreement shall provide funding for the home's total capacity of licensed or approved beds."

The benefits of these changes would be enhanced with an assurance that I will continue to have equal access to core program funding when funding devolves to LHINs. This can be achieved by retaining a common approach to funding core services, including elements of our current envelope funding system. This is a matter that we hope will be appropriately addressed in government policy.

Possibly the best opportunity for Country Terrace to contribute to the LHIN vision is in developing specialized programs that respond to our community's unique needs. I am referring to services such as geriatric mental health, peritoneal dialysis and after-stroke rehab. Stable centralized funding provides a platform for us to pursue these local opportunities without risking the erosion of our core services. This committee can provide LHINs with strengthened authority and flexibility to support such local solutions with a fair and transparent framework by amending part IV, subsection 19(1) to read: "a local health integration network shall provide specialized program funding as deemed appropriate to the health service provider, based on the local population's unique needs," and amending part IV, subsection 19(2) to read:

"The funding that a local health integration network provides under subsection (1) shall be on terms and conditions that the network considers appropriate with consultation with the respective health service provider(s) and in accordance with the funding...."

I would now like to comment on part V, sections 25 to 28, which deal with service integration. This is an area where additional clarity is also required, based on the fact that beds equal service in long-term care.

Simply stated, if the basic service in all homes is the same and the authority over that service already resides with the minister through control of the beds, then the application of integration orders and minister's decisions to operators should also be the same. I would therefore request that this committee exempt all licensed and approved bed operators from section 28.

I am a not-for-profit, licensed long-term-care operator. I provide the same service on behalf of government according to the same funding and rules as all other long-term-care homes. I therefore have difficulty with the concept that my residents should be treated differently or put at a different level of risk based on the type of operator who owns the home. This current effect of section 28 contravenes the concept of service equity. It is also unnecessary, given the control the minister will retain over all operators under the long-term-care homes act.

With the effective authority over our core services remaining central, it naturally follows that this should be supported by a uniform accountability structure that applies to all operators. Bill 36, however, creates the potential for the emergence of two parallel accountability processes: one local, from the service accountability agreements between the LHIN and operators, and the other provincial, from inspection criteria we expect to be outlined in the new long-term-care homes act. If this is allowed to occur, there will inevitably be inconsistencies between the two that will confuse operators, residents and families. It will also add unnecessary bureaucracy and costs.

Bill 36 can be made to eliminate this potential while effectively and efficiently supporting provincial performance accountability in long-term-care legislation. A single and consistent service accountability agreement would enable LHINs to discharge their responsibility for ensuring compliance with provincial performance accountabilities. This instrument would be similar in concept to the standardized service agreement that now exists between the ministry and all homes.

I ask that the committee add language to part II, subsection 20(1) and part IV, subsections 47(7), (8) and (21) to ensure that this standardized agreement is developed in regulation and that there is a fair dispute resolution process. Further, this language should stipulate that the development process should include consultations with sector associations. In Alberta, where total performance accountability was devolved to the local level, significant variations in basic services have resulted. We must ensure that we avoid this in Ontario.

I also don't think LHINs need 600 long-term-care homes lining up with other providers on their doorstep each year to negotiate and sign individualized agreements. The inefficiencies and cost of that bureaucracy boggles my mind. I would add, however, that I would expect to be directly accountable to my LHIN for any specialized local services I provide. I am sure that these one-offs can be easily amended to a service accountability agreement which is otherwise standardized.

I would also suggest that LHINs retain the current Ministry of Health and Long-Term Care action line as the process for addressing public concerns. Part II, section 5, clause (d) seems to indicate that LHINs would develop their own processes. I believe that adding 14 additional and potentially different complaint processes is costly and unnecessary.

1030

I would now like to briefly comment on three other elements of Bill 36. As a small provider with limited administrative resources, transparency is important for ensuring that I have an equal opportunity to participate in service integration and that this process is accountable. This can be supported with provincial guidelines to define Bill 36's "community of persons and entities involved with the local health system in planning...." As a provider, I would like to be consulted in this process.

Transparency can be further supported by language in part II, subsection 9(3) to ensure that the conditions under which a LHIN board can hold in camera hearings is defined in regulation. It is critical that key decisions, particularly those related to service integration, not be made behind closed doors. Without this transparency, these decisions will be suspect by providers and citizens alike, regardless of their impact.

As a provider and a nurse, I was particularly encouraged to see the implementation of a health professionals advisory committee in part II, subsection 16(2). The potential benefit of this initiative could be greatly enhanced with language to specify the committee's term and mandate and to define in regulation that it contain a minimum of one regulated health professional from each sector. It is critical that health professionals with specific knowledge of individual sectors be available to advise LHINs. Inasmuch as we are the same, our clinical settings are often distinctly different.

Finally, as you may know, long-term care has an umbilical relationship with the community care access centres. All residents require CCAC approval to be admitted. A smooth working relationship helps ensure that system resources are effectively utilized to provide care to people where and when they need it.

We view Bill 36 as an opportunity to resolve some long-standing issues with placement and an emerging opportunity to utilize placement more effectively to achieve the LHIN vision, particularly in facilitating placement processes between hospitals and long-term-care homes. Legislators can help set the stage for this by encouraging effective placement accountability measures in the service accountability agreements between LHINs and CCACs and by encouraging that the regulations governing both hospital and long-term-care admissions be mutually supportive.

In closing, I again thank you for allowing me to make these remarks. If you take away one thought from them, let it be that as a provider and an Ontarian, I share much of the vision of this bill. I also believe that it needs some adjustments to make it work for both those who deliver and those who receive long-term-care services.

The Chair: Thank you very much for your presentation. There is no time for questions.

CHARLOTTE'S TASK FORCE FOR RURAL HEALTH

The Chair: We'll move to the next presentation, Charlotte's Task Force for Rural Health. There are three presenters, I believe. Welcome. You can start any time you're ready. We have a total of 15 minutes, and if there's any time left, there will be some questions for you.

Mr. Norm Sutherland: Good morning. I'm Norm Sutherland, a member of Charlotte's Task Force for Rural Health in Petrolia. I will make a five-minute presentation, followed by a five-minute presentation by Mary-Pat Gleeson. Helen Havlek is one of the resource persons on the task force.

Charlotte's Task Force for Rural Health is an advocate on behalf of the citizens of rural Lambton county. We believe that all citizens are entitled to timely accessibility to a full-service general hospital within the geographic boundaries of their community. We were formed just over a year ago in response to our communities' concerns around the erosion of essential services and experienced staff at our rural hospital because of amalgamation with a larger hospital corporation. We have held public meetings to inform Lambton county communities of our findings and have received the overwhelming support of residents.

We are here today because we want to be certain that our residents have a voice in the future of our health care system. We believe that issues can only be resolved through open and frank communications among all sectors, and that the health care needs of rural communities must be acknowledged.

All the great presentation pundits tell us not to start off with negatives, but this is such an egregious negative that we must bring it to your attention. If you look at the ad that was in the papers across the province, you are holding meetings in Toronto, Ottawa, Thunder Bay and London. There is not one small or rural community mentioned. Why can't government agencies, just once, travel to rural Ontario? Please understand that to us this urban-centric focus is symptomatic of an inability or unwillingness to understand the needs of the rural community.

Having said this, we believe there are positive ideas in Bill 36. We believe that the vision itself of local communities being responsible for their own health care, the concept of local budgetary control and governance, the recognition by the ministry of the importance of primary care that has been overlooked until now, the guidelines and standards in place to ensure fiscal responsibility and transparency, and the concept that the government wants to create a sustainable health care system are all good news.

Keep in mind, however, that previous attempts to create cost-effective systems have resulted in many small, extremely efficient and cost-effective hospitals, like Petrolia, Newbury and Picton, being absorbed by larger city bureaucracies where the deficits are now crippling the system.

We are here today to help you understand that larger is not always better. We are here to suggest that even the Health Services Restructuring Commission under Premier Mike Harris acknowledged the need for rural, full-service hospitals. We hope to ensure that you do not abandon that concept.

Now, let's talk about rural health. What works in the city does not necessarily work in rural communities. It is well known that rural populations have a higher incidence of illness, accidents and death rates. The following are just some of the challenges that impact the delivery of health care in rural communities.

Transportation: There is no public transportation system in rural areas. Distance is a factor, and weather often plays havoc with the ability to travel to larger

centres. Seniors in particular wisely restrict and limit themselves to driving locally and will not venture into large urban centres.

Let's look at the population base in rural areas. Lambton county, as an example, has the highest senior citizens' rate in the province, so accessible health care services are crucial. As the size of rural hospitals shrinks, the number of doctors attached to them decreases. The number of doctors decreases. Community care access centres have been touted as a replacement service for services being eliminated from small and rural hospitals. In the case of Lambton county, the CCAC office has been moved to Chatham, at least an hour from most of rural Lambton.

We have the highest teenage suicide rate in the province. After the social worker for outpatients was removed from our hospital, we called the Sarnia CCAC office concerning the needs of a suicidal teenager. The answer from the caseworker was that she might be able to give support over the phone. Previously, the teenager could have walked to the social worker's office. So there is a huge gap between what is promised and what is being delivered.

The thoughtless elimination of experienced resource nurses affects the delivery of quality care, particularly in emergency departments of small and rural hospitals. As an example, in rural areas, there is a higher incidence of accidents that require specialized knowledge. Victims of strokes and heart attacks must be diagnosed quickly; the increased time in getting a patient to a well-staffed emergency department is a matter of life and death.

In her paper in the spring edition of the *Canadian Journal of Rural Medicine*, Dr. Trina Larsen Soles, president of the Society of Rural Physicians of Canada, points out that by urbanizing health care both in location and philosophy, rural people are discouraged from using the system. Dr. Larsen Soles went on to suggest that if rural residents cannot access the system, they will simply all die off—another way of reducing costs.

Ms. Mary-Pat Gleeson: Let's look at issues raised in Bill 36 itself. The boundaries of the LHINs were determined by patient referral patterns. Our patient referral patterns, as the ministry has been told by Dr. Kathy Pratt, on behalf of the Lambton county medical association, are from west to east, not north to south. We are at a loss to understand how our patient referral pattern could possibly indicate Windsor as our tertiary centre. The boundaries of the Erie-St. Clair LHIN raise several other questions. How does a geographic area of this enormous size, which covers territory from Grand Bend to Windsor, define "local?" How will the LHINs guarantee that there is no restriction of access to other LHINs when we are seeing restrictions already?

Moving on to other issues: How is the definition of "integrate" as set out in Bill 36 any different from the mandate set out by the Harris government's Health Services Restructuring Commission? Mr. Harris won an election by stating he would not cut hospital services and then invented a supposed arm's-length commission to

make the cuts for him. Are the LHINs the reincarnation of Mr. Harris' commission?

Have your strategic plans included public input, especially from rural communities? By "public" we mean ordinary citizens, not just health care professionals and bureaucrats.

1040

Bill 36 lists cost effectiveness as just one of its objectives. However, the CEO of the Erie-St. Clair LHIN stated publicly that cost effectiveness was one of the most important parts of the equation. Which is it? Are LHINs to be more concerned about cost or patient care?

Small and rural hospitals have proven to be cost effective for various reasons. They are close to their community and there's a sense of ownership that ensures accountability and staff commitment to that community. Bigger is not always better. For instance, a smaller hospital's share of the administration costs is higher in an amalgamated corporation.

Integration has not saved money. Have you looked at other ways of saving money? Perhaps small, efficiently run hospitals are one way. We know from a recent edition of the *New England Journal of Medicine* that a study at McMaster University indicated that for-profit health care costs more money than publicly administered and provided health care. Creeping privatization will not save money.

Bill 36 states that there will be a system in place for auditing performance standards, targets and measures, performance goals and objectives. What action will be taken if standards for performance and outcomes are not met? The lack of public education about the bill sends up a red flag.

What is the basis for setting standards? Is it quality or is it cost? When the only criterion for setting standards, targets, measures, goals and objectives is achieving the lowest cost instead of providing accessible highest quality, the result is the inevitable rationing of services. We've seen that rural communities are the first in line to suffer. The extraordinary needs of rural communities must be considered.

We would like to continue by offering constructive suggestions that we feel are important to consider as amendments before Bill 36 can be passed into law. We have identified a basket of services which must be listed in Bill 36 as being necessary for rural hospitals. These include: emergency services that provide 24/7 access to physicians and experienced nursing staff certified in cardiac life support and trauma care; in-patient beds for medical and surgical services; all diagnostic imaging except CAT scans and MRIs. Critical care services: operating room services for emergency and elective surgeries, clinics, full laboratory services, full-time pharmacist, full-time social worker for both in-patients and out-patients, dietitian and support services. We know from our own experience with CEE Hospital in Petrolia that these services can be provided in a rural setting both efficiently and effectively.

Suggestion number 2: In order to be accountable to the public and the ministry, and to avoid self-perpetuation,

the governing body of the LHINs should be elected. The board should meet more than four times a year. May we suggest 12 times a year, minimum.

All information coming from the LHINs should be made readily available to local communities. May we suggest that it be placed in our MPPs' offices and the clerks' offices of local municipalities, in addition to doctors' offices and hospitals.

There must be a patient's bill of rights included in Bill 36.

There must be a legal avenue in place for the public to appeal decisions made by LHIN boards. To be allowed only to appeal to your executioner is ludicrous.

It is obvious to us that one of the nagging concerns that people have with the LHINs is the size of the geographic areas they encompass. We are suggesting that before you institute the LHINs program across the province, a pilot project of a smaller LHIN, based on county boundaries, be put in place. We are suggesting that Lambton county be that pilot project. Let us show you that smaller can be effective and efficient while providing quality care.

In closing, we would like to reiterate our concerns for rural health care. Rural health care has exceptional needs that must be met in the bill. While we applaud the bill's philosophy of including the public in the decision-making process, in reality, sadly, the bill lacks any meaningful or significant participation by the public.

I hope you can understand that our recent experience dealing with health care administrators and bureaucrats has given us little comfort. We are counting on you to protect rural Ontario.

The Chair: Thank you for your presentation. There's about three minutes; one minute each. Mr. Arnott, you're first.

Mr. Arnott: Thank you very much for your presentation. In listening to it, I'm sitting here thinking, what would Lorne Henderson have to say about Bill 36?

Ms. Gleeson: I think he probably would have cheered us on.

Mr. Arnott: I think he would have indeed. For those of you in the room who don't know, Lorne Henderson was a long-serving member of provincial Parliament representing Lambton. After he retired from the Legislature, I used to run into him at the OHA conferences, where he served as a volunteer board member of one of the local hospitals in Lambton county.

I would agree with you completely: There has to be some sort of appeal board for LHIN decisions. If you're appealing to the same people who turned you down in the first go without any prescribed format for how they would engage in public consultation, there is going to be a real problem, for rural Ontario in particular. Would you envision a provincial appeal board for the whole province, or would you suggest that there should be a local appeal board for each individual local LHIN? How would you structure it?

Ms. Gleeson: I suppose it would have to be a step-up program; in other words, it would go to the supreme court of LHINs. It has to be a system that will work for

the public, and that's not so heavy with jargon and bureaucracy that it's not accessible. The whole point is that people feel they can appeal and are not going to be turned away by the bureaucracy.

The Chair: Ms. Martel.

Ms. Martel: Thank you very much for being here today. You've described to us some of the challenges you've faced in the past and said at the start that you're hoping that the vision of local communities being responsible for their own health care, as described in the bill, will probably make things better. But I wonder if you can comment on the fact that the LHINs are essentially creatures of the province. I have my serious doubts about how much local community control or input there is going to be.

I'd ask you to consider this in the bill. It's very clear that cabinet—the government—creates, amalgamates or dissolves the LHINs. The LHIN boards of directors are appointed by the province; they serve at the behest of the province. The only members of the LHIN non-profit corporations are their directors themselves, which is different from hospital boards, for example. The LHIN is explicitly defined as an agent of the crown in the legislation. The LHINs are funded by the ministry "on the terms and conditions that the minister considers appropriate." The LHINs may fund health service providers, but that funding has to be "in accordance with government requirements, including the terms of the funding that the LHIN receives from the ministry, the terms of the accountability agreement by which it is bound to the ministry and other requirements that cabinet"—government—"may prescribe," and the list goes on.

If those are the conditions under which LHINs are set up and operate, how much room do you see there for control at the community level by the community?

Ms. Helen Havlek: We don't see very much control at the community level. We think there's enough information and statistics and everything else around that these decisions can be made not based on emotion but based on real needs. That seems to be the problem: The actual needs of people are not listened to or don't have any effect with the government. This is not just this government; most governments act in the same way. Having elected representatives makes it necessary for those people to respond to the needs of their community. They can't get away with not doing that because they'll be turfed out the next time. That's one of the reasons why we like the election part of it. Also, as we mention in our brief, to be able to actually talk to people and have the common person's input is a difficult thing. Service providers can do that pretty well, because they have spokespeople or somebody who talks for the union or for the service provider or whatever. But the common person has difficulty, I think, in being able to express their concerns.

The Chair: Thank you. Mrs. Van Bommel, please.

1050

Mrs. Maria Van Bommel (Lambton-Kent-Middlesex): I certainly welcome my constituents to this. I'm glad you've taken the opportunity to avail yourselves of

this democratic process. For all the people who are here, Petrolia has a wonderful history of defending rural health care. When the restructuring commission came through under a previous government, they were stopped dead in their tracks at Petrolia by the citizens of Petrolia. I think most of rural Ontario has Petrolia to thank for that.

There are a couple of different things I wanted to address. One is the concerns Mary-Pat expressed about costs, and that this is a way to reduce costs. But I've spoken with the Minister of Health, George Smitherman, and I know that for him the priority here is coordination and delivery of better services. That's a very important thing for me as well in terms of rural health care. I agree: Bigger is not always better. We certainly have a long way to go in making sure that rural health care is delivered in an appropriate way, but I believe that LHINs are a big step in that direction.

One of the other things you talk about is the boundaries of the LHIN. I know that in Petrolia and in the Sarnia area, there has been a lot of controversy about the issue of where you would be able to go for care. I can assure you—and I have spoken with the minister's staff about this as well—that there is no boundary in terms of where patients can go for health care. You can go where you feel the services are best delivered to you. This is about coordination of good service. The LHIN boundaries are not a restriction on the constituents in my riding in terms of where they can best get their services. If you feel that your services are best delivered to the east of you instead of to the south of you, you can use that as your way of getting the health care services you need.

I'm not going to ask a question, because I know these people have the best intentions for their community and I applaud the fact that they've taken the time to come here. Thank you very much.

The Chair: Thank you for your presentation, and enjoy the balance of the day.

Ms. Havlek: I just want to say that we've already met with barriers. We've been turned down by the London tertiary centre because they said we're not in their LHIN. If they don't get the money to serve us, how can they serve us?

The Chair: I'm sure that your local MPP will follow up on that. Thanks for letting us know—or anybody else, for that matter. We can continue this discussion.

CANADIAN HEARING SOCIETY, LONDON

The Chair: We'll move to the next presentation. We're just a little behind. The next one is the Canadian Hearing Society, London. You can start whenever you're ready. There is 15 minutes' total time.

Ms. Marilyn Reid: Thank you very much for having us today. My co-presenters are Diane Robitaille, who is a consumer of our agency and also a counsellor with our agency. Beside her is Marilyn Bullas, who is also a consumer and is a member of our community development board here in London. They'll be assisting me, sharing some of their experiences and some of their issues.

In terms of the Canadian Hearing Society and who we are, we were founded in 1940 and provide a whole range of services to enhance the independence of individuals who are deaf, deafened and hard of hearing. We have 28 offices across Ontario, and a presence in each of the 14 LHINs.

In terms of statistics, hearing loss is one of the fastest-growing disabilities in North America and is going to continue to grow with increased noise pollution and aging of the population. As a younger member of the baby boom population, we're coming along, so we're going to see increased numbers. According to StatsCan, 10% of the population suffers a hearing loss, and as I said, that's going to grow. So it's going to impact a significant number of people in Ontario.

In dealing with people with a hearing loss, we basically have four different groups that have very different access, support and communication needs. To explain what those four groups are and what they need, I'm going to ask my colleague Diane to talk about the first two groups.

Ms. Diane Robitaille (Interpretation): I'm a culturally deaf person, and there are people like me who require ASL to communicate and use interpreters. For clarification, I should say that's ASL or LSQ, which is langue des signes Québécois. Our communication needs are through ASL English interpreters. We often also use real-time captioning, like you see here, and communication devices such as TTY, teletype or telephone devices, as well as a variety of visual amplification or visual sound devices like baby monitors or doorbells that actually flash a light, and things of that nature. There are also oral deaf people who choose to speak and communicate in that way. They often rely on speech reading and real-time captioning, and many people are also now using cochlear implants.

Ms. Marilyn Bullas: My name is Marilyn Bullas, and I am a deafened adult. I was a hearing person until four years ago, when I suffered profound hearing loss. Deafened is different from hard of hearing. Hard of hearing is much more common, especially as people age. They have nerve deafness and become hard of hearing.

This hearing loss for me was a devastating time. Although I could speak, I was unable to understand speech. I couldn't hear the phone, I couldn't hear the door, the alarm clock, the smoke alarm. Understandably, I felt very frightened and vulnerable. My children were most upset. My son called the Canadian Hearing Society in a panic, asking for help. Within a week, assistive devices were brought to my home, explained and set up for me. My councillor offered to speak to my family and friends. But most of all, she taught me to hear differently.

Speech reading, closed-captioning and real-time captioning, which this is, were introduced to me. It was such a relief to know that with practice, people could learn to speak clearly to me. My life is different now, but it's good. I have made many friends among the hard of hearing who rely on hearing aids and captioning as well. I have had a cochlear implant also, which has provided

some improvement for me. But I want you to know that sitting back there without the captioning, I hear nothing; I hear a little rumble, but I hear nothing. I look normal, I think I act normally, but I'm anything but normal.

We have an ongoing support and advocacy group through the hearing society, which has really enriched my life. Part of our advocacy is trying to get more of this real-time captioning in theatres and other places. There's very little that I can do without captioning. With that one phone call four years ago, the Canadian Hearing Society has met my communication needs in a timely, expert manner. Their service is unique and irreplaceable.

I would like to make one more comment in terms of having the sign-language interpreter and having the captioning here. It's available for two hours and was kind of fussy to set up. I wonder how acceptable it would be to have the room wheelchair accessible for only two hours.

I know that I'm a voice crying in the wilderness, because there aren't very many of me, but I just wanted my voice heard. Thank you.

Ms. Reid: Just to add to that, I think Marilyn is certainly not alone in terms of her access needs.

I think the other group that we talk about, and that Marilyn mentioned, is the hard of hearing Ontarians. That's probably the majority of individuals you may have had contact with. They do have spoken language. They also use all the same access needs that Marilyn would use.

I think that every Ontarian has the right to access to health care, and yet, as we can see even at this meeting, there are barriers in terms of accessing the meeting.

We support the basic concepts and philosophies of the LHINs. We see that there are three major issues with respect to the legislation that, again, we want to highlight. The first is accessibility, obviously; the second is the central versus the community roles; and the third is the possibilities for system integration.

I am going to ask Diane to talk a little bit more about accessibility.

1100

Ms. Robitaille (Interpretation): Accessibility: When you're talking about geographic accessibility, there is a lot of concern around appropriate services being in one's local community area. Where disabilities are concerned, for people with disabilities access means something different. According to the AODA, the piece of legislation that was passed only last year, the issues and the mandates that have been established in that legislation must be followed in the development and implementation of Bill 36 so that all barriers are broken down.

It is critical that all accessibility needs are met within the local health care service providers. In the Eldridge decision in 1997, the Supreme Court of Canada decided that the human rights have already been declared and decided and that access to health care is mandatory in all environments for people with hearing loss. So in the implementation of the new LHIN system, from the groundwork up it is critical that all health care providers and all the health care services are made accessible to

people with all disabilities, particularly people who are deaf, deafened and hard of hearing, as we've already mentioned, as an expanding community of people due to the aging population. Their needs are going to be critical and must be a priority in the provision of health care services.

I'm here today with an ASL interpreter only for an hour. That service should have been made available for the entire day and all of the proceedings taking place here.

My experience has been that when I go in with my husband to the emergency room it's often a 12-hour stay, and that entire time is taken up without any kind of ASL interpreting provided. So I'm meeting doctors and nurses without having access to communication and information. This has been a gross frustration over my lifetime. Occasionally, if you find a particularly willing doctor, they may take the time to write the explanation of whatever the issue is that you're being seen at the hospital for. But that rarely happens. In ASL, the information is much clearer, it's more accessible. It's my first language. In English, it can be very frustrating, because not all the terminology is necessarily understood and it can be just as frustrating as not having the information at all.

Thank you very much.

Ms. Reid: In terms of community roles, the concept of responding to local needs is admirable, but again, we need to look at it being equitable across the province. We want to stress that it be accessible for all individuals.

I have just been told that I have less than a minute now, so I guess our last word that we really want to stress is the need for specialized services for the deaf, deafened and hard of hearing across the province. Our agency has the unique skills and knowledge base to address those needs, as Marilyn has pointed out. Again, we stress the need that access be in place across the province. LHINs have the opportunity to set the stage for that access.

The Chair: Thank you for your presentations. There is no time for questioning.

GUELPH WELLINGTON HEALTH COALITION

The Chair: We'll move on to the next one and call on the Guelph Wellington Health Coalition. Is Magee McGuire in the room? Is anyone from the Guelph Wellington Health Coalition present? Good morning. Please have a seat, madam. Anywhere; there are two chairs, so wherever you prefer. Whenever you are ready, you can start your presentation.

Ms. Magee McGuire: Good morning. I timed this last night; it's about two minutes over. I'll try to shorten it as I go along.

The Chair: Okay.

Ms. McGuire: My name is Magee McGuire, and I chair the Guelph Wellington Health Coalition. I'm also a nurse with 35 years' experience; I've just retired. I worked mostly in clinical units, with short stints in emer-

gency and critical care, and I also worked in community clinics in Toronto.

The vision of our coalition is for all Canadians to have access to health care according to the principles of the Canada Health Act. Our mission is to educate and inform the general public about the status of the first tier of our health care system, the one for everyone regardless of economic or social status. Our mandate is inspired by the desire of 80% of Canadians to reform the weak links in public delivery and strengthen accountability.

The local health integrated network, or LHIN, mimics the current government policy to apply management principles of private enterprise to the public health sector. Its priority is fiscal, not people. It does not address its impact on social fabric.

We note that the LHIN has a definition and clear goals, but no implementation plan. We want to address the latter in respect of the huge losses our community has endured. We want to connect it to issues of privatization. To evaluate its worth, consideration will be given to its character as a co-dependent provider of opportunity for private, for-profit health delivery.

We cannot endorse private clinics that require membership fees for prevention services. These are not essential. There is no legislation to exempt these members from returning to the public system. It is not acceptable that our elected representatives want to abdicate their job to be the hands-on providers of the one-tier, publicly funded and delivered health care system.

I wish to digress for a moment. We have two other tiers. One is an insured tier that covers extra services covered by private plans. Then there is a third tier, where cash is required for all of these services. We pay regular tax contributions to health and the recent health tax of Ontario, 2004. Don't you think the private dollar is already paying enough?

Wait lines are the issue. We do not endorse the sensationalizing of wait times over someone's death. The real source of the problem is in the funding or in the delivery.

The principle behind the Harris cuts was to save and to reduce deficit. Now we know from CIHI that the cost per capita for health care has increased less than a full percentage point since the 1990s. So what is causing this deficit? It's not transparent. The real drivers for these costs are not in patient care but in drugs and technologies. What are the plans for reducing these drivers?

The current government justifies private partnerships in hospital care, which the LHIN will administrate. However, this is wasted time and effort, because it will not produce the doctors and nurses we need to shorten the wait lines, nor will it save dollars or lives. According to the American Journal of Medicine and the Canadian Medical Association Journal, both peer-reviewed magazines, research was printed that demonstrated both higher death rates in for-profit hospitals and higher costs. I have attached these research articles.

So we're asking again, how will the LHIN increase the number of doctors and nurses in the public system? How

will it ensure that there is no brain drain away from our region or public hospitals? What disincentive will it give to queue-jumpers? How will it prevent the private clinics from snatching up all the lucrative, low-risk patients who will not need the post-op care in an intensive care unit or need longer-term recovery? To date, day surgeries have provided efficiencies for the public system. Cataracts, tubal ligations and hernia repairs are but a few of the day surgeries. If this is so lucrative to the private sector, why is the public system not organizing hospitals that have ORs sitting idle to do this surgery more frequently? Lastly, how will the LHIN be able to sustain itself?

1110

The LHIN executive has responsibilities not unlike those of a CEO, a human resources director and CAO. In fact, one wonders if the job of the hospital executives of the same name will become obsolete in their organizations. After all, it will be duplication.

These were the people most responsible for the restructuring of the years 1998 to 2002. They received their orders from the Ontario Hospital Association, which, in turn, was agreeable to the cutbacks.

Also, it is clear that the LHIN policy is about restructuring. However, it lacks a clear implementation plan with constructive details that clarify the need for the goals, and it lacks an evaluation component to measure the impacts.

To evaluate, we would like to stress the outcomes. We can predict the outcomes of this legislation best by looking at what happened to Guelph in the last round of restructuring, whose methods of implementation are now known to us—kind of a mini-meta analysis; that is, forecasting after the fact. Plus, we can name goals achieved and measure their efficacy by the outcomes.

In Guelph, the satisfaction of patient surveys after restructuring stood at 70%—doing its very best. The greatest good that came from restructuring was the formation of purchasing consortiums, a leap out of the skin of the silo. Yet the silo, in a city where there is only one acute care facility, is still a fact of life. We are still not holistically engaged as health providers.

I will now list what we have lost in Guelph due to the restructuring. In home care, we lost nurses and home-makers—never replaced nor increased for the ever-growing home care sector. Remember, home care was to take the convalescing hospital patient into the home to decrease the costs of running a hospital. Remember, there was no funding shifted to home care to take on this burden. It is not an administrative solution we needed; it was physical bodies to do the work. Hours of service were lost. Overburdened families returned the patients to the hospital.

For palliative patients, the scenario became even more dire. The qualifications for extended care hours for the dying patient requires a predictable estimate of six weeks to time of death. Are these uncompassionate goals the stuff of government stewardship? Whether you planned it or not, what you have achieved is the goal you achieved.

Must I rant about the competition? Do these outcomes demonstrate that the home care sector is more effective

with its piecemeal schedules, its record duplication and its inability to continue to meet the requirements of a stable but very ill patient?

Remember, elderly people were to be encouraged to stay in their homes longer. The cost of a weekly homemaker was certainly much cheaper than the minimum of \$1,200-a-month room and board in a retirement or nursing home. But this service too has been restricted. Now increasing numbers of people wait for nursing homes close to their families upwards of two years.

For hospital patients ready for discharge to extended-care facilities, there is minimal to no choice of placement for this patient. It may be several towns away.

Then there was the loss of acute care beds. Medical beds were reduced—our population is 120,000, by the way—from 60 to 42, pediatric beds from 40 to 10 and surgical beds from 30 to 24. We lost an acute care hospital with its own emergency and critical care services, and the emergency services were transferred to the Guelph General Hospital months before the funding was in place. The danger of this situation for months should never have been overlooked.

We lost staff when two hospitals amalgamated on the pretence that the alternate hospital would be specialized as a rehab and chronic care hospital. Within two years, the rehab hospital, which never received its full funding for rehab, was demoted to the status of a long-term-care facility and lost its special funding. There is one RN and two RPNs to care for 36 dependent patients on the 12-hour night-shift.

We lost staff trust and morale when nurses were laid off and the bumping started. Trained RPNs were forced to bump into housekeeping, dietary and ward clerk positions just to keep a job. Interpersonal conflict is now a big workplace issue.

We lost the head nurse position to a business unit manager position, requiring hours of meetings and little time for staff interaction or patient communication, major complaints excepted. The solution was to take a nurse off the floor and make her a charge nurse to reclaim the fort and be at the beck and call of both manager and bedside as well. Complaints, you say? Well, they just never seem to stop any more.

We lost in-house laundry, we lost the outside grounds-keeper and we lost the in-house painter, yet these seem to be daily, ongoing services. They're all contracted out. We don't know what the cost comparison was. No one knows.

We lost a nurse educator who for years would orientate staff, supervise the new skills and update staff uniformly.

Nurses use a recognized measuring tool for their work by law. The numbers indicate increasing patient hours and not enough nursing hours to cover the cares. They are ignored because of budget constraints over which they have no control or input. The increased stress is leading to increased sick time, combined with increased overtime hours, not to mention increased injuries. This is a significant fact because, as you know, payroll makes up 75% of hospital budgets.

We lost doctors and nurses to the US due to lack of jobs. The 8,000 nursing jobs promised to Ontario have not materialized. The outcome is long wait lines for all services. By prioritizing the five areas of medicine to meet provincial benchmarks, the wait lines in other areas are going to be longer. Are we happy yet?

We lost time to give foot care and back care. A tub bath is rare. We lost the evening snack for all patients except diabetics or hypoglycemic patients.

We lost dedicated housekeepers so that the nurses have to pick up the slack, and some never do. Now we are incorporating the metal giant, the computer, known to be a sinkhole for time, known to excessively tire us and negatively—we now know—affect our intelligence. Wouldn't you know it? The doctors do not have to learn this until 2007. Only the nurses and the rest of the hospital have to learn it.

We have lost our public lab because the funding was not there. Guelphites now have a choice of several private labs to go to. Prices for infrequent tests are not standardized. The unsuspecting patient is a victim.

We have lost our range of responsibility for city and township to larger areas. Critical care now has to admit patients from St. Catharines because of lack of beds there, even though the patient is routed there because they require tertiary care, which this hospital is not funded or staffed for. The extra cost comes out of our local hospital budget, and the occupied bed is closed.

We just lost 12 transition rehab beds, and we're going to lose our outpatient chemotherapy department.

Labour is going to have a blow as we now lose more jobs.

So where in these goals is the vision of health care for Joe Public in the realms of safe and competent delivery? These outcomes speak for themselves.

We believe that with each deficit that appears, another service will be lost. Staff reps will be lost. Rights of staff and patients will be eroded. There will be more amalgamations and contracting out, bigger workloads, union amalgamations, loss of bargaining units and benefits. Pensions will be affected. There is no sunset clause.

When the hospital can't operate, it will have to close its doors or sell. This will be taken up by a private investor, who then will open this up to foreign investment because it's protected by the law of NAFTA.

So tell me, with lower wages and job losses, where's the government going to collect its tax? Certainly not from the corporations to which it gives these tax cuts.

We've lost perspective. Quality is defined only by specific, best-practice treatment of a patient.

Then there are doctors. We're sure that they will love working in these chaotic conditions and encourage their children to study for medicine. I'm sure they will turn their patients and wipe their noses. It is strange that they're exempt from this LHIN process, for they are part of the very survival of health care in any form.

Three generations ago, their fathers traded chickens for services. They need to be partners in this.

The Chair: Thank you.

Ms. McGuire: I just have one more.

We're concerned about the democratic aspect of the LHIN, the lack of checks and balances for Joe Public to address inconsistencies of this government or future governments. There's no legislative passage to ensure the protection of the principles of the Canada Health Act, and the Minister of Health has set himself up as the wizard.

So the process by which the LHIN has come to be is incomplete, and it's also out of traditional order—no white paper and no first round of meetings recorded that we can refer to. At these hearings, we have incomplete information. What is this plan going to cost us? What's it going to save us? Where are our tax dollars going?

1120

These goals are the ones that we see that the government will achieve. Is that what it wanted? Outcomes are the true goals achieved. Outcomes in a health system are measured in people satisfaction, in death rates, in social responsibility.

We have given you some of the predictable red flags of the LHIN in its present form. Reform now means "destroy"; change now means one more tier of finance. It is not incongruous to suggest that this government cannot see the invisible and therefore it cannot do the impossible.

Thank you very much.

The Chair: Thank you very much for your presentation. We have the entire package, all of us here, so it's all on public record. Thank you again.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1, LOCAL 145

The Chair: Is anyone from the Service Employees International Union, Bluewater Health, present? Claudette Drapeau and Ann Steadman. You can start any time you're ready. There's a total of 15 minutes.

Ms. Claudette Drapeau: It'll be short and sweet. Hello. My name is Claudette Drapeau and I'm an RPN at Bluewater Health and co-chair of SEIU, Local 1, in Sarnia.

I am here to appeal to your sense of propriety. I am not opposed to change, but I am against inequity and the demise of our health care, which should be made available to all Canadians, regardless of their status.

The LHINs structure is undemocratic. Health care does not need more bureaucracy. With the LHINs being appointed by the government and accountable only to the government, who will serve the people? How can you justify spending \$52 million to hire 550 new bureaucrats, and add to this \$200 million to set up a new LHINs organization, while not one cent—not one cent—is being utilized to add a single family doctor, medical specialist or direct hands-on care provider to our health care system?

Fourteen million dollars had to be cut from Bluewater Health, which resulted in 164 professionals being laid

off. You cut at our local levels to balance so-called budgets and turn around and create another expense that does not serve the people. Health care taxes should be utilized for what they were intended for—health care. The Liberal government is not being accountable to the people, and our tax dollars are being wasted on bureaucracy while people are dying waiting for care.

How can you ensure that there is a clear understanding that patients can continue to receive care across LHIN boundaries? We are always going to be closer to London than Windsor, so will our referral process continue?

Some things may work in Toronto, having one hospital do all hips, knees, etc., but that won't work in smaller communities, and Sarnia is a smaller community. If you move a service such as hip and knee surgeries to one location, we will lose our orthos, and then our emergency department will not function as needed and down we go. How is this going to benefit our community? Does the government equate the reduction of services to better health care?

Will our rural hospitals be nothing more than walk-in clinics? How are senior citizens expected to shoulder the cost of travelling expenses on fixed incomes? Secondly, can you ensure their safety on our major highways during inclement weather?

I have been told that they can rely on family. Well, not all senior citizens have that privilege, and for those fortunate enough to have families, again, there will be a cost: lost wages, hotel bills, meals, etc., and additional stress due to travelling highways and having to leave a loved one behind in a strange city.

People are not just cases; they are individuals with physical and emotional needs. By putting senior citizens in disorienting environments without family and moral support, you decrease their chances of a quick and full recovery. It seems to me that only the rich can afford this new health care system. The poor and the senior citizens will be left out in the cold.

Our hospital, Bluewater Health, is a community focus point and it is staffed with professionals who are educated to respond to extreme emergencies. We live in the Chemical Valley, where first response must be upheld. We cannot afford a second-rate, substandard health care system which can jeopardize the lives of our citizens in our community. By contracting out services to the lowest bidder, you put us at risk. You will lose stability and gain greater disparities.

Clearly, this legislation is jeopardizing every health care worker's livelihood. The government wants to remove the protection of the current collective agreements, debase staff to work at lower wages and remove their hard-earned pensions, with no benefits. Odd, don't you think, for a health care worker to be working in a hospital for a private company yet have no health benefits? The Liberal government is attempting to balance budgets on the backs of workers, with total disregard for the chaos and hardships it will create. Displaced non-clinical service workers will have no right to transfer their union contracts to the for-profit private

providers of non-clinical services. It is essential that a human resource plan be developed. Health care sector workers' rights must be protected.

You need to meet and have dialogue with front-line health care workers to find resolution, people with integrity and common sense who understand what is at stake and understand the needs of the patients. Do not put our health care system in the hands of bureaucrats and businessmen who have a different agenda and who are ignorant of the dynamics of true health care. Do not pass this flawed legislation. Thank you.

Ms. Ann Steadman: My name is Ann Steadman. I am an occupational therapist and the unit chair of OPSEU Local 145, Bluewater Health, Sarnia. I come before this body to express a few of my many concerns about the local health integration networks, LHINs, as proposed under Bill 36. This bill, supposedly about the transformation of health care, will result in ongoing health care chaos and instability.

First, this bill has been implemented, in many ways, without due process. Before these hearings and prior to a third reading in the Legislature, LHIN CEOs have been hired and board members appointed. In fact, the LHIN CEOs have been on the job since August 2005. Thirteen of the 14 CEOs are reportedly making some \$225,000 a year; one is getting \$325,000 annually. Other than meeting and greeting, renting office space and hiring some staff, can the government point to anything else they've done for a cost of some \$1,624,000? This amount of money would fund Sarnia's much beloved but endangered palliative care unit for a year.

Second, the government calls these proposed new bodies "local health integration networks." I would suggest that this name, LHINs, is a misleading and deliberately inaccurate description, designed to fool the public into thinking that there is some local control going on. LHINs have nothing local about them. Rather, the government is putting into place RHINs, regional health integration networks, another layer of bureaucracy insulating the government from the public.

What does "integration" mean? My dictionary tells me it means "to form, coordinate, or blend into a functioning or unified whole." However, the ministry defines "integrate" to include "transfer, merge, or amalgamate, to start or cease to provide services, to cease to operate." Given that the LHIN-appointed CEOs and board members are accountable to the minister, not to their communities, how can any community be assured that a LHIN CEO and/or board will be able to forcefully represent their community's position when what is right for the community is in conflict with a ministry direction? Where are our checks and balances?

Further, these regions are very large. Sarnia-Lambton is in the Erie-St. Clair LHIN, which stretches from Grand Bend in the north to Pelee Island in the south and consists of three counties: Lambton, Kent and Essex. The LHIN boundaries do not represent medical referral networks that are historically and currently in place. In Sarnia-

Lambton, we relate to London, not Windsor, which is at least a two-hour drive from Sarnia in good weather.

Third, across the province, the appointed LHIN board members have a stunning lack of health care experience. As for our CEO, the same could be said. The Erie-St. Clair LHIN CEO has no health care experience. He is a former telecommunications industry executive. This point was brought home when he stated in a public forum in November that he didn't know what community care access centres, CCACs, were until last summer. Will the board members and especially our CEO, lacking health care backgrounds, understand the key elements for delivering good patient care?

1130

Finally, the human resources issue has not been adequately addressed. Quality patient care depends entirely on the quality and continuity of the staff providing that care. This legislation opens the door for the competitive bidding of service provision and an ongoing process of service transfers and amalgamations, a sure recipe for health care chaos and permanent instability. We have already been down this road in Sarnia-Lambton with our CCACs. We've been through three rounds of requests for proposals. There have been significant changes in service providers, with the resultant disruption to patient care and dislocation of workers. In one case, a new-to-the-area, low-bidding service provider got contracts for both nursing and homemaking and ended up having to default on the nursing contract within one year.

Already, Bluewater Health and the Chatham-Kent Health Alliance are sharing occupational health staff. Essentially, what were three full-time-equivalent positions at Bluewater Health have been cut in half, and this is just the beginning of an erosion of local services and local jobs. As this process continues, workers will be forced to drive great distances to keep their jobs or be forced to choose between their communities and their jobs. This will lead to a recruitment and retention nightmare at a time when there are substantial shortages in many key health care professions.

How can we attract young people into health care professions when the future is so uncertain? To put patients first, the government must ensure both the retention and recruitment of health care professionals. LHIN bureaucrats will not be providing patient care. Care means health professionals at the bedside, in the labs, running MRI and CAT scanners and providing rehabilitative services.

I urge the McGuinty government to put the brakes on this LHIN implementation. Stop the LHINs before they literally crash our health system. Postpone this legislation until a comprehensive strategic plan is developed in consultation with all stakeholders.

The Chair: Thank you for your presentation.

We have about three minutes left, and I would ask Madam Martel to start, please.

Ms. Martel: Thank you, both of you, for coming from Sarnia today to make this presentation. I wanted to ask you a question about competitive bidding, or cutthroat

bidding, which is the way I normally describe it. The minister, in his opening statement yesterday, said we were going to hear a lot of misleading information—that was his word, not mine—at these hearings from critics of the legislation, that one piece of misleading information we were going to hear was that, through this process, LHINs were going to purchase or acquire services through competitive bidding, and that nowhere in the legislation was that referenced. Nowhere in the legislation does it say they're not going to do that, either. So what is the government's intention? We already know they have not changed cutthroat bidding in home care. Despite the review by Elinor Caplan, it still goes on.

From your perspective, because you have seen how this has operated in your community, why would you be worried about cutthroat bidding being extended from home care to all the other services that LHINs are expected to purchase in the future?

Ms. Steadman: To recap what we've seen happen in Sarnia-Lambton, we've had three rounds of requests for proposals. In the first round, a very long-established large company, ParaMed, ended up being gone. In the second round, VON lost their homemaking contract, Lambton Elderly Outreach lost theirs and, as well, a small community occupational therapy service organization was cut. That's when We Care was introduced, and that's the company that defaulted on nursing. In the third round, another large, significant service provider, Comcare, left.

This means that as soon as a service provider leaves, all their employees are out of work. Typically, because the bidding tends to go to the person putting in the lower bid, workers are then picked up at lower rates of pay. That's our basic concern. If we see this translated throughout the rest of the health care system, I think you'll see, again, more chaos and less patient care. Getting back to the CCAC situation, it's exceptionally disruptive for someone who is elderly, for instance, and maybe has had a homemaker for a few years—the homemaker has almost become part of the family—when that homemaker is yanked out of the situation because of a bidding process.

The Chair: Mr. Ramal.

Mr. Khalil Ramal (London-Fanshawe): Thank you both for coming from Sarnia. Just for the record, you mentioned that our government cut your budget. As a matter of fact, we have a record showing we gave you an extra \$13 million. Also, the budget for Sarnia hospital: over \$600 million. So we never cut your budget.

Also, I don't understand how you can describe the LHIN as going to affect health delivery. I don't know if you were here listening to my colleague Maria Van Bommel from Lambton-Kent-Middlesex when she was talking about when she had to communicate with the minister in terms of, if you want to seek some kind of service in your boundary, whatever you prefer, you can go to it, and the LHIN is not going to affect that service. It is, as a matter of fact, working at the administrative level in order to consolidate the health delivery.

Ms. Drapeau: That's good to know, but I want to say that we, as employees at Bluewater Health, were cut \$14 million. They claimed we were \$14 million over budget and they cut. So services were lost. To say that you've given the hospital money, it wasn't enough.

Mr. Ramal: This increased the budget \$13 million.

Ms. Drapeau: Increased the budget. We needed a \$14-million increase, sir.

Mr. Ramal: We never cut the budget.

Ms. Drapeau: We lost. They cut our budget \$14 million. They claimed that we were \$14 million over budget. So we had to lay off 164 professionals from the hospital, and we had to decrease services and amalgamate services.

The Chair: Mr. Arnott.

Mr. Arnott: Thank you both very much for your presentation.

Ms. Steadman, I was pleased that you raised as your first concern the fact that Bill 36 hasn't been passed into law, and yet the government has moved forward, showing what I would characterize as profound indifference to the Legislature and the role of the Legislature, which is to look at these bills that are introduced in the Legislature, debate them at length and allow for public input before final decisions are made. Yet the government has appointed LHIN boards, has appointed CEOs—you've described some of the salaries. There's something really wrong here when the government shows this kind of indifference to the legislative process. Would you not agree?

Ms. Steadman: I would call it disrespect.

Mr. Arnott: Would you call it contempt of the Legislature?

Ms. Steadman: Yes, I'll be led into that.

The Chair: The 15 minutes are now over. Thank you for coming and sharing your opinions.

COMMUNITY CARE ACCESS CENTRE OF WATERLOO REGION

COMMUNITY CARE ACCESS CENTRE OF LONDON-MIDDLESEX

The Chair: There is another presentation before we break, from the Community Care Access Centre of London-Middlesex and the Community Care Access Centre of Waterloo Region. Are they in attendance at this time? Please have a seat. There will be a total of 15 minutes for your presentation and potential comments and/or questions.

For those who have an agenda, the 11:30 presentation has been cancelled. That's why there is only one left before the break.

You can start any time.

Mr. John Enns: Good morning, Mr. Chairman and members of the committee. I'm John Enns, chair of the Community Care Access Centre of Waterloo Region. It is a great honour for me to come and speak to the standing committee on social policy today. I'd particularly like to

acknowledge Ted Arnott, the member of the Legislature on the standing committee who represents our riding in the Waterloo-Wellington area and with whom the CCAC of Waterloo region has had the privilege of interacting over the years.

As one of the founding board members of the CCAC of Waterloo region back in 1996, I felt, as does the board of directors, that it was important to come here today and provide the committee with our input on the proposed legislation, Bill 36. I must tell you that we consulted with the CCAC of London-Middlesex, and because our views on Bill 36 are in agreement, we decided to do one presentation so that the committee would not have to hear the same message twice.

I have asked Kevin Mercer, the executive director from the CCAC of Waterloo region, to make some comments today. Sandra Coleman, executive director of the CCAC of London-Middlesex, is also here with us today and is available to respond to your questions.

1140

Before I ask Kevin Mercer to address you, I did want to emphasize that we support this legislation in terms of the development of the local health integration networks and also in terms of the amalgamation of CCACs within LHIN boundaries as noted in section 15 of the proposed legislation.

In our opinion, the proposed legislation will allow community care access centres to further advance our organizational vision and mandate. Our vision, which was developed in consultation with our stakeholders, clearly highlights the importance of the pursuit of integration. I want to take a moment and read you our vision, because we plan and prioritize our activities around this statement: "The community care access centre"—of Waterloo region—"is a leader in delivering integrated health care through innovation and partnership to an aware and informed clientele."

In other words, our organization has always focused on integration and planning of services in partnership with providers in all program areas in health care, with the school system and with a number of social services. As an example, recently we developed, in partnership with the Waterloo Regional Police, an elder abuse prevention team.

CCACs are all about integration, creativity and flexibility across the numerous silos in the health care system. We are not about organizational structure. We are about the services that we can make happen and the difference we can make in the lives of the people we serve. Our most significant partners, our clients, need an organization like ours to help them understand and access the various options of community-based support when they require assistance. Our case managers do that. They are at the front line. They have been referred to as both "knowledge managers" and "boundroids" because they know how to move across the various boundaries and the silos in the health system to ensure that our clients get the service they need when they need it.

So this legislation, Bill 36, is going to advance integration of services for the client. From our perspective,

addressing the fragmentation, inconsistency and siloed nature of health care in Ontario makes sense, so we urge you to move forward with this legislation. Ontarians will thank you for it.

As well, the intention to move CCACs back to community-based organizations with local membership and locally elected boards is a positive step. The plan to remove the order-in-council appointment process for board members and executive directors within the next two years is supported by our board. We believe that with community membership and community selection of board members, there is a stronger community ownership of local planning and resolution of issues. From the beginning of the order-in-council appointment process for CCACs, the finalization of appointments has been a slow process and not always respectful in terms of recognizing the contributions of volunteers. These are key governance changes that are welcomed by our board.

I would now like to ask Kevin Mercer to make a few comments, following which we, along with Ms. Coleman, will answer, to the best of our ability, any questions that you may have.

Mr. Kevin Mercer: It's a pleasure to be here, Mr. Chairman. I want to share with you comments developed by the CCAC of Waterloo Region and endorsed by the CCAC of London-Middlesex in relation to advancing health system integration in Ontario. The comments are in relation to three specific areas: first, case management and system navigation; second, investing in community-based services; and third, proposed amalgamation of CCACs in Ontario.

Case management and system navigation: In June 2005 at the Ontario Association of Community Care Access Centres annual convention, the Minister of Health and Long-Term Care, the Honourable George Smitherman, clearly challenged our sector to move beyond our traditional roles and functions in the plan to transform health care in Ontario. Mr. Smitherman said, "Home care is the linchpin in our plan for health care. We will be counting on CCACs not only to continue doing the great work you have been doing, but to persistently push yourselves to do even better to deliver to Ontarians the care that they need."

The challenge from the minister was taken very seriously across the province by the CCACs. When we reflected on where we could add value to the health system and transformation initiative, clearly the area of system navigation was identified. As care is being shifted from institutions and acute care to the home, it is essential to guide clients in terms of the options and the supports that are available to them. Case managers are able to link and coordinate service delivery in an increasingly complex and ever changing health system.

Case management is the mechanism for making sure integration, health promotion and disease management can occur. As we engage in the transformation proposed in the establishment of LHINs, case management is a core service. With the support from the Ministry of Health and Long-Term Care, CCACs and their partners are positioned to have a positive and immediate impact.

In the OACCAC provincial report on health system navigation, there are six recommendations on system navigation currently being pursued by CCACs: Improve system access by expanding the CCAC information and referral function; introduce and include CCAC case managers in family health teams; merge the role of hospital discharge planner and the CCAC hospital case manager; initiate planning processes among partners to develop disease management strategies; advocate for the development of province-wide health care strategies for sub-populations; and, finally, initiate a process to develop evidence-based best practices for all initiatives.

We recently amalgamated discharge planning and case management at Grand River Hospital in Kitchener. In collaboration with the hospital and the Ontario Nurses' Association, we created a harmonized role of case management/transition planning. Tremendous duplication was eliminated and system navigation was enhanced. Patients in the hospital now receive support from one person with an integrated role—it's client-centred and more efficient. The CCAC of London-Middlesex is exploring these opportunities as well with their London hospital partners.

A plan is evolving to have case managers become a part of family health teams in Waterloo region and also in London-Middlesex; they are integral to community health centres currently. The potential role of case managers in system transformation ensures that clients do not fall between the cracks. We believe this is very significant.

Investing in community-based services: The region of Waterloo is comprised of 490,000 people and is one of the fastest-growing areas in Canada. In 2005-06, with a budget of \$47 million, it is projected we will help more than 22,000 individuals and their families, providing approximately 230,000 nursing visits, more than 550,000 hours of personal support and homemaking, and more than 72,000 therapy service visits. In addition, the CCAC of Waterloo Region will assist 2,500 people with the process of transition to long-term-care homes. London-Middlesex is similar in size to Waterloo and serves a comparable client base.

Over the past year, both the CCAC of Waterloo Region and the CCAC of London-Middlesex have experienced caseload growth of more than 15%. As further integration of services continues and community-based alternatives to acute care are expanded, continued growth in the investment in home care is important. It is also important to realize that the aging population and the current strategies to divert hospital admissions have increased home care caseloads.

As acknowledged by the OACCAC in its presentation yesterday, there have been significant investments in CCACs over the past two years to avoid and substitute for hospital services, to reduce wait times for hip and knee replacement, expand access to peritoneal dialysis service, increase access to post-acute home care, expand end-of-life care and develop a consistent client screening and assessment process. These investments will have to

continue as the health system transforms. We have the studies and data to prove that making these investments reduces hospital admissions, ER visits and return rates and reduces hospital length of stay.

We understand that there is a significant multi-year federal funding agreement specifically committed to home care for acute and palliative clients which will result in base budget increases for the next several years.

The plan to allow LHINs to redirect savings from integration activities noted in subsection 17(2) is also an opportunity to provide the additional resources that will be required to meet increasing demands for home care and community-based services.

1150

Amalgamation of CCACs, part VII of Bill 36: An important component of Bill 36 is the amalgamation of CCACs within LHIN boundaries in Ontario. Once again, as identified by the OACCAC yesterday in its presentation, "There is a significant level of support among CCACs for consolidation and alignment." The CCACs of Waterloo region and London-Middlesex are part of that significant support and have advocated for CCAC consolidation for more than a year. Our analysis has identified the following benefits that derive from amalgamation:

(1) provides clients with consistent and equitable access to CCAC and community support services within the LHIN boundaries;

(2) supports the development of an integrated risk management strategy to effectively identify and manage potential areas of risk such as communicable disease, community emergencies and disasters;

(3) potential to redirect efficiencies resulting from consolidation to enhance client care and to fortify unmet need such as specialized geriatric services;

(4) uses existing networks to improve access to specialized resources such as restorative justice;

(5) aligns with already established and developing networks such as the regional cancer centre, regional cardiac centre, hospice palliative care network, stroke strategy, hospital networks and numerous other LHIN-wide initiatives;

(6) leverages and facilitates broader expansion of best practices and excellence in community care;

(7) builds on existing complementary vision and values of neighbouring CCACs;

(8) stabilizes community-based human health resources resulting from RFPs issued over a broader geographical area. The resulting economies of scale benefit clients, provider agencies and staff working in this sector;

(9) creates a community-based, system-wide platform:
—to promote dialogue leading to a common set of community-based performance indicators and care maps;
—to identify and meet health needs of populations served;

—to facilitate accountability to the LHIN for community services.

There are decided benefits in amalgamation, particularly in light of Minister Smitherman's commitment that

local presence will be maintained through the local community- and hospital-based offices of the CCACs.

Mr. Enns: Mr. Chairman and members of the standing committee, once again thank you for the opportunity to present our thoughts to you. In closing, I wish to reiterate our support for this legislation and would urge you to proceed with the passage of this bill. This will ensure that CCACs are amalgamated across the province within LHIN boundaries and will result in an enhanced client-centred system of community health care.

Mr. Mercer, Ms. Coleman and I are happy to answer any questions you may have.

The Chair: We've run out of time, but we do have a few minutes because somebody cancelled. Do you wish to go for a minute each? Why don't I start with you, Mr. Arnott, seeing as they are from your area.

Mr. Arnott: Your presentation is very comprehensive and self-explanatory, but I do want to thank the board and staff of the CCAC of Waterloo Region for the outstanding work you do here.

Mr. Enns: Thanks, Ted.

Ms. Martel: I have a question. On page 8, you say, "The plan to allow LHINs to redirect savings ... noted in subsection 17(2) is also an opportunity to provide additional resources." So I go to subsection 17(2) in the legislation and I see it says the following: "When determining the funding to be provided to a local health integration network ... for a fiscal year, the minister shall consider whether to adjust the funding to take into account a portion of any savings from efficiencies that the local health system generated in the previous fiscal year and that the network proposes to spend on patient care in subsequent fiscal years in accordance with the accountability agreement."

You choose to read that as saying that the LHIN is going to get its budget and the savings. I read that to open the potential to the savings being deducted from the budget. What guarantee do you have from the minister that the reference to savings is in addition to the budget and not a subtraction from the budget in that fiscal year? The legislation doesn't say "in addition to."

Mr. Mercer: In responding to that question, there is no guarantee in the budgetary process, and we all know that from experience as you develop a budget. But in the spirit of the legislation—we're looking at the objects of the LHIN, and we're assuming from the objects of the LHIN that we are seeing a philosophical shift occur in health care, being promoted through the legislation, that would allow the creation of innovative opportunities that do create efficiencies and those efficiencies being reinvested in areas that are identified as being deficit in a particular LHIN area.

The Chair: Mr. Leal, the last question.

Mr. Jeff Leal (Peterborough): I just want to follow up on that line of questioning, because it's certainly my understanding that the minister has been very clear that any LHIN savings within the geographic area of a specific LHIN would be used to fund those priorities that the LHINs themselves identify. For example, in my area

of Peterborough, we have a high degree of seniors, and the CCAC in my community is very excited about the LHIN legislation and getting those extra dollars to put in to address the priorities, particularly of home care, in my community, which has that large seniors population. Could I just get you to comment on that?

Ms. Martel: Where is it in the legislation?

Mr. Leal: I'm asking this gentleman a question, Ms. Martel.

Mr. Mercer: The other component, reflecting on your question, is that the reality is that the LHIN is going to be developing an annual plan that they submit that will define the budget for the given LHIN area. Once again, reflecting on the objects of the LHIN, we believe we're going to be part of that process and we're going to be able to put forward the efficiencies that we identify, and then we'll be able to reinvest those in the program areas that have been identified.

Mr. Leal: And improve patient care.

Mr. Mercer: Absolutely.

The Chair: I thank you all for your presentation.

We are breaking until 1 o'clock, when we'll be back in this room to continue the presentations.

The committee recessed from 1155 to 1305.

The Chair: Can we start the meeting, please? We are a few minutes late.

ONTARIO NURSES' ASSOCIATION, LOCAL 100

The Chair: The first presentation comes from the Ontario Nurses' Association, Local 100, London. You can start any time. There are 15 minutes in total, and any time you don't use will be available for questions and/or comments.

Ms. Vicki McKenna: Good afternoon. My name is Vicki McKenna. I'm the first vice-president of the Ontario Nurses' Association and a member of Local 100 here in London. With me today is Lawrence Walter. He is ONA's provincial government relations officer.

I'm a registered nurse and have been nursing full-time since 1979. I've been nursing in London in the day surgery/day medicine units, caring for adults and children, for 20 over years now. I did work in the United States for one year as a new graduate, and I can tell you that I came back to Ontario as quickly as I could. I don't want nursing in Ontario to ever operate like it often does there for patients and for nurses, where profit motivations impact on patient access and the quality of care that can be delivered.

I want to start by telling you that we have more than 7,000 members in the London area, what we refer to as region 5 within our structure within the Ontario Nurses' Association, and the surrounding two local health integration networks, or LHINs. We have registered nurses and allied health professionals working in all sectors currently included under Bill 36, including hospitals, community care access centres, long-term-care facilities, and public health, which is excluded from the legislation.

Yesterday in Toronto the committee heard three overriding concerns from ONA's president, Linda Haslam-Stroud, key reasons as to why ONA does not support the approach to integration set out in Bill 36. I won't repeat those concerns, but I do want to repeat to you that ONA leaders are speaking out on Bill 36 precisely because nurses are vitally interested in a positive outcome for health care reform in London and in communities throughout Ontario, not only for our professional interests but for the patients we care for.

Registered nurses know too well the consequences of not getting health reform right. Nurses work daily in life-and-death situations. Mistakes in health care design also have very serious consequences. We agree with the minister that we have to do this right.

Today I want to review additional issues for nurses relating to effective and meaningful collaboration with input from the community and front-line health care professionals and their representatives.

We are concerned with the lack of adequate provisions in Bill 36 regarding input and collaboration in the establishment of local integrated health services plans; input from the community and front-line workers into the LHINs integration decisions and funding decisions; a meaningful oversight of integration and funding decisions, which will have an enormous impact on both the patients we care for and the health care workers themselves; and insufficient accountability into the ongoing provisions of health care services under the LHINs.

We believe the purpose of the bill should be to implement seamless health care. Legislated mechanisms for effective input from employees and their representatives can assist with this transition and, we believe, avoid disruptions in the continuity of care for our patients and the working conditions for the staff that deliver that care. Under Bill 36 as currently drafted, this puts in place a framework for the consolidation of services and disruption in service delivery which undermines patient accessibility, service provision and quality care.

First, we would like to comment on the appointment process for the LHINs boards, which has been conducted entirely under ministerial control. Our members ask why a democratic process for an elected board could not have been implemented which would allow for real community input and representation into the integration decision-making processes undertaken for their area. Rather, what we see is the ministry retaining a tight control on the LHIN board through the appointment process. From the very first act related to the establishment of LHINs, control has been set up to be exercised from the top down, not through community involvement.

We will also be making proposals regarding conflict-of-interest guidelines for LHIN board members that will ensure consistency from network to network, including oversight by the provincial ethics commissioner.

Let me turn to the provision in Bill 36 that currently sets out a requirement, in subsection 16(2), for the creation of a "health professionals advisory committee" by each LHIN. You might think this would be a require-

ment that would hold some appeal for registered nurses and allied health professionals who belong to the regulated professions. However, after a closer review of the requirement, you might note that there is no definition as to the composition of the committee except that it's to consist of members from the regulated health professions as the LHIN determines or as prescribed. There is no process for the selection or appointment of these members of the regulated health professions.

We've had some experience with health care committees where health agencies have appointed who sits on the advisory committee. I can tell you that the experience has not been very productive or very conducive to a collaborative relationship. "Why?" you might ask. Well, for one thing, often senior nursing managers are appointed to such committees to represent the interests of front-line nurses. This, of course, never really works out very well since, by definition, they don't really have current knowledge of front-line nursing issues from the perspective of front-line nurses themselves. In addition, this requirement does not set out the roles for the advisory committee or the obligation on the part of the LHIN.

1310

Accordingly, our proposal is that this advisory committee needs to be made up of front-line professionals and that they be given a meaningful role in decision-making, including advance notice of meetings, disclosure of relevant information and planning documents, and the opportunity to actually be heard.

In addition, we believe that restricting input to an advisory committee of regulated health professionals excludes the constructive and welcome input from the non-regulated group of health care workers. For nurses, who are used to working in teams every day, this exclusion seems unwarranted and unhelpful to this commitment of collaboration. Therefore, we'll be proposing that there should also be a health sector employee advisory committee.

I would like to turn now to the requirement for each LHIN to undertake community engagement in the development of a local integrated health service plan and in the priority-setting process. From the perspective of health care workers and their unions, this provision is extremely weak. It does not set out specific requirements for each LHIN, nor does it set out any common requirements across LHINs. We believe it's important to ensure that a process is set up that mandates a consistent public process with clear guidelines.

As currently drafted, Bill 36 does not give unions a role in the decision-making process that flows from the local integrated health service plans, even though integration decisions made by health service providers or imposed by LHINs or by the ministry can have a huge impact on union members, both in the way we deliver care to our patients and in our rights and working conditions.

It's our view that all interested stakeholders—the community and health care employees and their unions—should be given notice of intended integration decisions,

with the opportunity for input, before the decision is finalized. In addition, we're proposing that unions be given notice of final integration decisions by health care providers, LHINs, the ministry or cabinet, if our members are affected, well in advance of the implementation of those decisions.

I'd like to move at this point to what we believe is a failure of Bill 36 to provide a meaningful oversight or review function of integration and funding decisions determined by each LHIN. Currently, the bill does not provide a mechanism to review integration or funding decisions. We'll be making proposals that a review process be established. At the moment, Bill 36 provides for a health service provider to request reconsideration of a decision by the LHIN itself, and for review by the courts.

In our proposal, we believe an independent body such as the Ontario Health Quality Council could be charged with reviewing integration decisions against the criteria of public interest. We believe the Ontario Health Quality Council is well positioned to take on this review function, given the nature of its work and its access to information. This review process would allow for closure for a community that disagrees with the integration decision determined solely by the LHIN.

The final area of concern we'd like to address today relates to accountability agreements and subsequent compliance reports. Currently, Bill 36 provides for accountability agreements between the minister and each LHIN to be made available to the public at the offices of the ministry and the LHIN. This is appropriate, but we believe that all accountability agreements should be made public. However, accountability agreements presently being established between the ministry and health service providers will not be made public. Furthermore, once the LHIN takes over funding in 2007, there'll be no requirement for the next round of accountability agreements between the LHIN and health service providers to be made public. The main point here is to ensure an open and transparent process during health reform decisions and during ongoing accountability for implementation.

Contrary to the minister's views expressed yesterday in Toronto, our intention is to improve the health reform being undertaken, to get it right, so that it provides a firm foundation to build a genuinely integrated health care system. For that reason, collaboration, effective input, oversight and public accountability are all key elements to ensure a successful health transformation in the public interest. But, as is the case in most things, the devil is in the details. We believe Bill 36 requires that much more attention be paid to the details of quality patient care, community input, and local accountabilities.

Thank you.

The Chair: Thank you. We have about three minutes available, Ms. Martel, if you wish to start.

Ms. Martel: I just want to focus on your point that the accountability agreement should be public. From the broadest possible perspective—and I appreciate that suggestion—I agree with that and I can tell you that we've

had some problems even with the current accountability agreements and getting information. We've been trying to get information from the ministry about the people who were hired through the CCAC process—what agencies actually got information. We've been told we can't get that because accountability agreements are only between the ministry and the actual CCAC. We have gotten nowhere, to date, trying to get really basic information about which agencies got public money through the CCAC. So I agree with you entirely in terms of the broadest possible public notice, so to speak, of who is dealing with whom and who is getting what. That's really what needs to be done, because we're talking about public money here, and that should be available to the taxpayer.

I just want to go back, though, to your appointment process. Why are you concerned about the current appointment process as it stands, which is essentially ministry-directed and ministry-controlled?

Ms. McKenna: We believe that this is fundamentally the most radical reform of health care in our province and that, if it is truly to be locally focused, then there needs to be true local representation there. The size of these LHINs is so vast that just by calling it local does not make it local. Therefore, we believe that there are people in our communities who are interested, who have the knowledge and skills and should be people who may well be represented by their communities and supported to be on their LHINs.

This appointment process is not about the people; this is about the process. I think that that needs to be an important point: that this is not personal; this is just the way a democratic, clear transparent process should happen. We don't believe that it is even close to that in the current structure of the LHINs.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I just wanted to pick up on that issue. One of the things that we're trying to do in this process is to learn from the experience of other jurisdictions that have gone through similar processes. I just wondered if you're aware that Saskatchewan, Quebec and Alberta all have moved away from elected boards because they couldn't find people who wanted to stand. It just wasn't working out, so they've moved to an appointment process. What we're suggesting is an appointment process that has the community nomination aspect to it, that the LHINs will be expected to get community nominations for people who would be able to represent the community and stand for appointment.

Can you just comment on that? Because it really is something that we're trying to improve on from other jurisdictions.

Ms. McKenna: I don't know the details of all the issues; however, I'm surprised that they couldn't find anybody who was interested in health care. That surprises me a lot. However, I don't know the total situation and will certainly be looking at that. The reality is that I don't really even know of any school boards where you can't

get people who want to run on school boards. We have municipal elections; we rarely have to fall back to appointments. Occasionally it happens, but health care is the number one priority in Canadians' minds and Ontarians' minds, and I'm very surprised that there wouldn't be people who would be interested.

Ms. Wynne: That's just the experience; that's what's happened.

The Chair: Thank you. Mr. Jackson, please.

Mr. Cameron Jackson (Burlington): I appreciate your presentation. The committee has heard some of the concerns you've raised. One of the aspects that is troubling me—I have spoken with two people who were appointed in the LHIN in my backyard, which is from Niagara to Brantford to Burlington. One of the comments that was made was that the minister indicated at the first meeting of people who had been appointed to the LHINs that he really wasn't looking for people with experience in health care. That troubled me a lot, because we are going to be making a substantive leap. These LHINs are extremely powerful and are going to be making decisions about service integration and the delivery of services, actually even trimming some services. Are you concerned about this concept that, that if you don't have a lot of experience in health care, you'd make a better candidate for the LHINs? I'm just following on the comments from the Liberals with respect to learning from other jurisdictions. But I thought we should have health professionals inside the tent, not outside the tent.

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Ms. McKenna: That's perplexing to us as well. It's a bit of a mystery. I can't say that I know the details of all the experiences that were spoken to and I'm not even going to guess how that came about. But yes, it's perplexing. It's a mystery to me why you wouldn't have people who might have some experience or knowledge of health care design, health care delivery, health care provision, actually planning health care. That would be where we would be going. However, it is a bit of an oddity in our minds, yes.

The Chair: Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 260

The Chair: The next is the Ontario Public Service Employees Union, Local 260, Owen Sound/Markdale. Are Mark Weston and Christine Coughlan present?

Mr. Mark Weston: Thanks for this opportunity to speak. My name is Mark Weston. I'm an addiction counsellor employed at the withdrawal management service in Owen Sound. I represent the service workers from OPSEU Local 260, at the Grey Bruce Health Services corporation in Owen Sound and the five outlying community hospitals in Grey and Bruce counties.

Our service workers are well-trained, hard-working individuals who are dedicated to providing quality services such as housekeeping, maintenance, kitchen,

laundry workers, registered practical nurses etc. Our workers support families and the local economy by spending their incomes in our communities. If the legislation is passed as it now stands, the future of these workers' employment will be uncertain. Entrepreneurs will see this legislation as an opportunity to rob our workers of their current standard of living while padding their own pockets with money. Eventually the quality, well-trained workforce we currently have will drift away to work elsewhere, free from the uncertainty and downward-spiralling incomes in health care. We will be left with a transient, unskilled workforce that is only committed to their employer until something better comes along.

The new era will bring in a centralized system that is not easily accessible by the aging and low-income population in our counties. Patients will have to travel vast distances to access treatment that traditionally was available locally. We will see patients die alone, distant from their families and friends. When consumers become disenfranchised from the delivery of health care, who will they complain to? Where are the checks and balances? Will they become trapped in yet another layer of a bureaucratic quagmire? Today, consumers can deal with issues quickly and efficiently at their local level. When the money and power become centralized in a dense urban community such as London, what becomes of rural health care in a community such as Owen Sound? We have already seen this happen on a smaller scale with all the hospital amalgamations. The outlying hospitals and consumers certainly didn't feel they were better off. Their resources were taken to balance the budget of the larger regional hospital.

In Owen Sound, we can't attract doctors. It will become even more difficult to find doctors when many of the services are located elsewhere. What would be the enticement to come to Owen Sound to work long hours with too many patients and to have to give up their care when they send them to London for treatment?

The majority of people in our province do not even know what LHINs are all about. The government has done a poor job of informing the people about the proposed legislation and its implications for consumers. Health care takes the biggest bite out of our tax dollars and therefore deserves to be given the scrutiny and transparency it deserves to all the people of our province.

Ontarians have made it clear that they want quality health care and they are willing to pay for it. They do not want "to the lowest bidder" health care.

Ms. Christine Coughlan: My name is Christine Coughlan. I work at Grey Bruce Health Services as a medical lab technologist at the Southampton site. We're one of the small rural hospitals that, when we were forced to amalgamate, did not go quietly. Our town is a resort town, a beautiful town on the shores of Lake Huron. We have a major employer, Bruce Nuclear Power Development, down the road. We are expecting an increase of employees, up to 1,500 contract workers coming in for the restart. We have a lot of retirees retiring to our area. Our hospital is very important.

Medical lab technologists are very vital to the health care decisions that physicians make. Last night, I was on call. I had to stay late, until 4:30, for a cardiac patient. The results were fine, normal; they sent him home. I went home and got called twice more, the second time, at 12:30, for the same patient for 4:30. This time when I drew his blood work, they were elevated. If our hospital or the lab weren't there as part of the decision-making, that patient could have died or would have had to drive another 40 minutes to get to the closest hospital, which is Southampton in our area.

The other four hospitals within our corporation are Tobermory, which is two hours from us; Wiarton, which is 45 minutes, with Meaford and Markdale over an hour's drive from our sites. Our site, with all these people coming and the influx of visitors and holiday tourists in the summer, being a very small hospital, has the second-busiest emergency department in our corporation, second to Owen Sound.

As medical lab technologists, we have guidelines to follow. We run controls. We have to make sure that our results are the correct ones for the patient. We are obligated to be in quality control programs from the government, some that we pay to go into. These are all so that the patient care is the best that we are able to do. From what I see about the LHINs, they are not accountable to anybody. Medical lab technologists are accountable to the doctors, to the government, to my boss and ultimately to the patients, who are the ones that matter the most. These LHINs do not seem to be accountable to the people they are serving. They are there for the patients, but there is no recourse for any patient or community if a decision is made that is not to the benefit of our community; there is nowhere for them to go to lodge a complaint or to have some input in this. There seem to be no checks or balances for the CEO or board members of the LHINs.

All these hospitals have foundations and they all seem to have people interested in running for these boards so they can keep the upkeep of these hospitals, so I find it hard to believe that there is nobody in these areas that would have the experience to be on these boards of the LHINs. The LHIN CEOs, from what I can see, report only to the minister. If that's the case, there is nobody else who can go to them, and that sounds like a dictatorship to me. Isn't that how scandal and corruption occur, when one person has too much power and has the ultimate decision on where it goes? Coming from a small community, that can spell a death knell for us.

These LHINs are modelled after other programs that don't seem to have done very well, so why are we as Canadians using this? Do we not have enough brains and thinking power to develop our own system? I cannot believe that, in all of our government, we do not have our own program that can take the health care, which people in the outside countries want to have—why we can't do this. When we adopted one of our children from an international adoption, there was a choice of giving him to a Canadian family or to an American family. The

organization was told to give him to a Canadian family because he had a correctable handicap and, in the States, they might not be able to afford to correct the handicap. It was very simple surgery, but in Canada, because of our health care, we were able to give this to our child. He is now able to run, skate and do whatever, whereas in the States and where he was from, Haiti, he would not have been able to do this.

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Politics seems to be very risky business, with democracy and voting and whatever. I did not go into politics. I wanted job security for my family and for me, so I went into health care, thinking that would be a good choice, that I could make a difference as a medical lab technologist because I see the patient every day. When I run my tests, because it's a small hospital, I know this patient X belongs to this result, and I know the history of these patients who come in because we see them a lot. For us, to have job security is really important. When the amalgamation came in, it was awful. The insecurity of not having a job is not very nice.

Our hospital, with all the different departments, is a vital link to our community, and we would like it to be there to help the patients, who are our families, grandparents and neighbours. Thank you.

The Chair: Thank you for your presentation. There is no time for questions, but thanks very much.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, SOUTHWESTERN ONTARIO

The Chair: Next is the Ontario Public Service Employees Union, southwestern Ontario, Ron Elliot. Good afternoon. You can start any time you're ready, sir.

Mr. Ron Elliot: Good afternoon and thank you for holding these hearings in London. I am Ron Elliot, OPSEU regional vice-president, and I will be making this submission on behalf of the 15,000 OPSEU members who will be affected by the proposed LHIN legislation and who live in the geographical areas covered by the Erie-St. Clair and the South West LHINs. Of the 15,000 members, 5,400 work in health care.

Today I'm going to talk about how the LHINs have been implemented with little community consultation, an apparent lack of comprehensive planning and under the veil of secrecy. For example, we're here today to discuss legislation that guides the formation of the LHINs, while in fact we know the LHIN boards have been appointed, CEOs and senior staff have been hired, and the 14 LHIN offices have opened.

We believe the government has put the cart before the horse: Change the health care system to show you're making change, without a plan and with as little public debate as possible. The LHINs are an old idea, which has been rife with problems in Great Britain and in Canada in provinces such as British Columbia.

Fourteen huge, unaccountable, unelected bureaucracies are being set up that will take at least \$55 million

out of the health care system. From last night, we now know that is a low figure, because the ministry has published figures that show that for 2005-06, \$40 million will be spent on LHINS, with practically no staff hired; they're not even up and running. Before this came out, our best estimate was \$55 million, but we were way under. The resulting chaos in our health care system will directly affect all Ontarians.

The district health councils were told in January 2005 that they would be closing. By March 2005, the workers were fired. District health councils were made up of members from the community and helped plan health care in local communities in Ontario. Effectively, there has been no health care planning in Ontario for over one year. About \$21 million was spent to fire the workers. The government has yet to report how many health care dollars were spent to cancel office leases and on other costs.

The ministry set up seven Ministry of Health and Long-Term Care regional offices in 1999-2000. The purpose was to plan, manage, fund and monitor the system of health care programs. These offices were staffed by professionals who came from the public service and health care services. These regional office public servants were accountable to the minister and the public. MPPs could request information from the minister, and ministry employees would provide the answers: a directly accountable system. Now the minister will be able to pass the buck and tell the MPP to go to their LHIN for answers.

On January 18, 2006, the seven regional offices were told they would close within 12 to 14 months. The staff learned of their precarious position by watching a video supplied by the ministry. The staff were effectively fired by video.

During the last provincial election, Dalton McGuinty promised to restore successor rights to public servants. He also stated that he valued our work. Well, we still do not have successor rights, and clearly he does not value our work. After being fired, our members in the ministry regional offices were told their jobs would not be transferred to the LHINs. We cannot understand the government turning their backs on trained, experienced and knowledgeable workers.

The seven regional offices will be replaced by 14 LHIN boards. At this early stage of the LHIN boards, the government has already cut their legs out from under them. The 14 LHIN CEOs were hired—appointed—by the government, not the LHIN boards. The South West LHIN CEO appointment is questionable at best. Did the government do any research prior to appointing the LHIN CEOs? A simple Internet search reveals a quote from a Deloitte and Touche inquiry into the North Bristol British National Health Service, managed by the new South West LHIN CEO, stating the executive group “was conducting its business in a dysfunctional, uncoordinated manner.” The trust was plunged into a £44-million deficit in 2002-03. The report further said that a “culture of fear” had prevented senior finance staff from speaking out. What a start to the LHINs.

The 14 LHIN CEOs are each being paid about \$230,000 per year in salaries alone, twice as much money as each of the seven ministry regional directors. The LHIN CEOs have been in place since August 2005 and have not contributed one thing to health care. Again, those are dollars out of the health care system for a new, expensive bureaucracy.

Further, there will be changes to the CCACs: 42 CCACs will be slashed to 14. Can you imagine what kind of service the CCACs will be able to provide in your home community, considering the huge geographic area covered by a LHIN? For example, you live in Long Point, located in the South West LHIN. One of your parents requires a bed in a home for long-term care. Suppose there's no space in the Long Point area, but there is space in Stratford. Will your parent be forced to move out of their community, leaving family and friends behind? Currently, as the population ages, there is no plan to build more homes for long-term care. We also know that long-term-care beds are not necessarily located in the communities where they're needed.

We question the LHIN boundaries. The ministry stated that they were set up along patient referral patterns. We can tell you that patients from Sarnia-Lambton, now in the Erie-St. Clair LHIN, are usually referred to London, located in the South West LHIN, for tertiary care. They are not referred to Chatham or Windsor, the other major centres in the Erie-St. Clair LHIN. As a matter of fact, when the ministry published the LHIN boundaries, they left some smaller hospitals off the map. Was this a mistake or future planning?

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The minister has stated that people will be able to cross LHIN boundaries for health care services, yet each LHIN will receive a specific amount of dollars to fund the services contained within their geographic boundaries. It does not take much imagination to foresee citizens vigorously guarding their LHIN-allotted health care dollars and questioning why citizens from other LHINs are using those dollars.

LHINs are not local. “Local” is a misleading term at best. The South West LHIN is made up of the following counties: Elgin, Middlesex, Oxford, Perth, Huron, Bruce, and parts of Grey and Norfolk counties, from Long Point to Tobermory.

The LHINs will pit community against community. In competing for health care dollars within the LHIN, we will see smaller hospitals, supported by the community with community funding, close. Employers want to locate their businesses in communities with hospitals. Hospitals are very important to communities. People identify with their hospitals. Community members provide valuable assistance to the health care system by doing volunteer work at hospitals and other health care services located in their community. Will they want to volunteer for organizations that are not based in their community?

Let's look at the LHIN mandate in the legislation. The LHINs have a legal requirement to continually re-

structure health care within their geographic boundaries. Health care has been going through restructuring for the past 20 years. There is a shortage of health care workers. Who would want to work in a system that is under constant change and turmoil? Health care workers have been beaten down enough. Morale is at an all-time low. For health care workers, restructuring means continuous worker turnover, with no job security.

The minister will be the grand puppet master of the LHINs. The legislation requires the LHINs to sign accountability agreements and follow the ministry's strategic plan. The minister determines the funding levels, the minister can veto or order integrations, and the minister approves bylaws and sets salaries. The minister has the power to add any health service to the LHINs. To us, this sounds like a job for the ministry.

With the minister and ministry in effect retaining control, why spend millions of health care dollars on the LHINs, which will not provide one additional health care service to Ontarians? Recommendation: Stop the LHINs now, before one more health care dollar is wasted.

Every citizen living in Ontario should be alarmed about \$21 billion of the provincial budget being transferred to the LHINs, nongovernmental organizations, the leadership of which is appointed by one person.

I want to thank you for listening to me. If you have any questions, I'd be pleased to answer them.

The Chair: Thank you. There is less than a minute each. We'll start with Ms. Wynne, please.

Ms. Wynne: Thank you for coming, Mr. Elliot.

A couple of quick points. The issue of the CCACs: I just wanted to make sure you were aware that, although there will be amalgamations, the 42 offices will remain open. So in terms of local service, that will remain.

Mr. Elliot: The legislation does not say that. They've already told the CCACs that the executive directors will be competing for their jobs.

Ms. Wynne: In terms of the administration, yes, there is going to be an amalgamation. I'm talking about the storefront. The offices will remain open. So in terms of service to people, people will still have access. I just wanted to make that point.

Mr. Elliot: Does the legislation say that?

Ms. Wynne: Well, the legislation doesn't have all of the implementation that will be rolled out as this goes forward.

Mr. Elliot: When will we see the rest of the legislation?

The Chair: There is one minute each, please.

Ms. Wynne: It won't all be in legislation; the implementation won't all be in legislation.

I think I've run out of time. I'll leave it at that. The service to the communities will remain because those offices will be open.

Mr. Elliot: How could the service possibly remain in the communities?

The Chair: Mr. Jackson.

Mr. Cameron Jackson: Thank you, Ron. I appreciate your presentation. I agree with a lot of the concerns you've raised.

When you talk about accountability agreements, are you concerned that they will also include confidentiality agreements? One of my concerns: My hospital just closed 10 beds on the weekend. I said that we'd need to tell our community. The CEO said, "Cam, the agreement we signed with the Ministry of Health, under Bill 8, says that I can't talk to the media." I said, "Does that include your board?" He said, "Yes. It covers all of us. We're not allowed to tell the public about these cuts."

Are you recommending that we have an override for these confidentiality agreements? I think they are as problematic as any of the accountability agreements.

Mr. Elliot: I think you hit the mark right on, Mr. Jackson. How the hell are we going to have a health care system that's secretive? It's the most important service to Ontarians. We just can't understand what the government is doing. If you look just at district health councils, \$21 million out the window. I don't know how many million bucks out the window for the regional offices; I don't know how much money out the window for CCACs.

The unions estimated this to be a \$55-million program, but already we found out it's a \$40-million program, although we've yet to determine how much the Liberal advertising agency, Avant, has taken of the \$40 million. Those are our health care dollars, for no services, which everybody in this room is interested in.

The Chair: Madame Martel, please.

Ms. Martel: Thank you for being here today. I think you're right. When I spoke about this legislation on second reading, I said that for most people, what is of most concern to them is getting the health care service that they need close to home, as soon as possible, by the same health care provider, on a continuous basis. There's nothing in the legislation that will ensure that the LHINs can do that. Frankly, that is a function of how much money is going into the system. That's determined by government. That's also a function of government policies and regulation: Who gets services, where, how much service they get in a CCAC. That's all done by regulation by the government. So the establishment of the LHINs will not change any of those basic concerns for people.

My overriding concern with the legislation continues to be the minister on the one hand saying that this is about local control and local communities making decisions, when, if you look at the legislation, it's all about even more excessive central control of every facet of health care. The LHINs are local in name only. They are appointed by the government. They serve at the whim of government. Their decisions have to be essentially in line with what the government dictates.

Given that that's the case, do you really see a whole lot of people on the ground having some ability to influence health care decision-making, when in fact the LHIN board members, for example, are accountable back to the ministry, not to the people whom they're designed to serve?

Mr. Elliot: Like I said in the presentation, it's going to affect volunteers; it's going to affect community spirit.

And they are going to close the smaller hospitals, as they are continually whittling them down. You know, some of the hospitals were left off the map of the LHINs. How would you like to come from those communities?

As legislators, you have to be concerned that \$21 billion is going to be shipped out of the provincial budget to what the minister states are, and this is a quote from the minister, "non-governmental organizations." Surely we have to be very concerned about that.

The Chair: Thank you very much for your answers and your presentation.

Mr. Elliot: Thank you.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 4186

The Chair: The next presentation is the Canadian Union of Public Employees. Is anyone here from the Canadian Union of Public Employees Local 4186, London? Yes.

You can start. You have 15 minutes. I'm just going out for five minutes, but Mr. Ramal will chair the meeting.

The Vice-Chair (Mr. Khalil Ramal): Go ahead, please.

Ms. Rosemary Van Niekerk: Good afternoon. I want to thank you for providing this opportunity. My name is Rosemary Van Niekerk. I'm a daughter of an aging parent, I'm the wife of an athlete, the mother of three children, and a grandmother. All of the family are active sports enthusiasts. I've come to appreciate my local health care services that are provided here in my community. But I'm also professional support staff. I work with special-needs children. I'm also the president of Local 4186, representing support staff employed at the London District Catholic School Board.

1350

We understand that the government wants to transform health care and some social services. The proposed Bill 36 will create a have and have-not split. This will undermine our public health care and public social services.

The legislation proposed at this time would allow for the creation of 14 local health integration networks, LHINs. The boundaries for these 14 areas were established over the past year. The local health integration networks referred to will encompass the planning, integration and funding for hospitals, nursing homes, homes for the aged, home care, addiction treatment centres, child treatment facilities, community support agencies and mental health services. Bill 36 is going to give our government and the LHINs an expansive and controlling power, all the power that will be necessary to restructure our local public health care and social services.

The LHINs will not be local decision-making bodies. They won't take into consideration our communities, our communities' wishes or our communities' needs. Bill 36 would grant little power to our community. The LHIN's board would decide when, where and even if a service is

warranted. The legislation will transfer the control of our community service providers to the minister and the cabinet or its agents, the directors of the local health integration networks. This process will take away our local autonomy. Bill 36 will grant unprecedented authority to the Minister of Health and the cabinet. This could completely restructure our health care. In fact, we know that community care access centres that play such a valuable role in our community would be consolidated and possibly turned over to for-profit corporations, with no consideration of community input.

The proposed legislation suggests local services, but the districts are far from local. The local health integration network will not deliver service directly and so will not be accountable for the shortcomings of services that will befall our community; the ministry would not be accountable, as they delegated this responsibility to the LHINs; and the local service provider won't be accountable, as they had to follow the direction given by the LHINs, and around we'll go: no accountability.

Bill 36 will create a purchase-provider split that will undermine our public health care. The proposed boundaries of the LHINs have been formed based on supposed hospital referral patterns. These boundaries are not local, they don't represent community interests, and they lack political coherence. How could a local health integration network adequately represent such a diverse and varied constituency? In fact, it couldn't. Even if the members of the local health integration network board wanted to take into consideration the local residents' needs, it simply wouldn't be possible.

With Bill 36, the cabinet may create, amalgamate or dissolve a local health integration network, with the boundaries ever-changing. The LHINs are governed by a board of directors appointed by the cabinet and will be paid at a level determined by the cabinet. The government will decide who will sit as chair and vice-chair of the boards. You will hold your seat and position on the board only as long as the cabinet dictates.

The government will control the funding for local health integration networks. The LHINs integration would have to fit the government's provincial strategic plan. As I understand it, the government may unilaterally impose an accountability agreement, with no input from the local communities. The LHINs will be responsible to the provincial government. There is a long history of public health care and public social services in Ontario. When the previous government attempted to cut funding to local health service communities, our community pointed out the problems that would be created. They engaged the public locally, and the government reconsidered. The proposed cuts were not implemented and the hospitals were allowed to meet the needs of their local communities. Public health care is still very much underfunded in Ontario.

One has to ask if Bill 36 is an attempt to silence the criticism of underfunding. The LHINs proposal replaces community service boards with government-appointed boards. We know that the community care access centres

were taken over by the provincial government in 2001. There was an immediate cessation of public outcry. That has resulted in dramatic cutbacks to those services. The most vulnerable in our communities—the elderly and disabled people in Ontario—have lost much of their home support services.

We know that government-controlled regional agencies are a poor model for the delivery of both health care and social services. They are neither transparent nor are they user-friendly. There is a very real perception that the LHINs are being orchestrated to insulate the government from future decisions that will privatize many of our public services and further cut back on the services that are currently provided. The local health integration network would become the scapegoat for unpopular decisions made by our provincial government.

Unlike the government, the LHINs would not be able to increase funding to provide or maintain services. Smaller communities would most likely be the first to see their local services integrated into larger communities. We're very fortunate living here in London. We have an amazing public health care system. It's world-renowned—both our medical practitioners and our facilities. Yet when my mother needed orthopaedic surgery, our health care community couldn't meet her needs. We had to go to Kitchener. But we were really fortunate: She only had a six-month wait, and the surgery was successful. But there's much pain and suffering in our community still. I know of one member injured at work two years ago who is still waiting for surgery. She had to go to Guelph to get diagnostic services that weren't readily available here in our health care community. And this is London: a major, well-known health service provider.

The LHIN structure will raise significant barriers to the control of local health facilities. It is likely that the decisions will take a bottom-line mandate, and the communities' service needs will be dictated by that bottom line. Yet the local health integration network will not be accountable to the community affected by its decisions.

Perhaps the ministry could consider approaching this proposed legislation from a slightly different perspective and include some of the following provisions:

- local health integration network boards would be democratically elected by all in the geographic area;

- selection of the chair and vice-chair would come from within the board;

- each local health integration network would be inclusive of a mandatory health sector employee advisory committee;

- the legislation would provide the right for a full judicial review and reconsideration by any person or trade union of any local health integration network;

- the legislation would ensure that no public service positions would be privatized;

- competitive bidding will not be recognized as a way of conducting business;

- language would be included that would prevent the further privatization and contracting out of our public services for profit.

1400

The seamless care that the LHINs proposal suggests will not be realized. This legislation will further fracture the delivery of service, as there will be increased competition for health dollars. Services will be cut. We all know that cutting back support services puts us all at greater risk and often mandates that higher-paid staff assume the responsibilities formerly carried out by support staff workers.

The government's endorsement of the plan to turn over the clerical services and the supply needs of dozens of hospitals in the north to a new employer—the NOHBOS—is alarming. In Toronto, I understand that the same approach is being endorsed.

My experience with the London District Catholic School Board has taught me that if the legislation or the collective agreement doesn't speak specifically to "no contracting out," you'd better be forewarned because that's probably the intent that's going to present itself. At the London District Catholic School Board, contracting out was approved as a cost-saving measure so as to better enable the school board to serve the needs of students. The health care providers—the LHINs—will use the same arguments, suggesting that these jobs aren't essential, and they are.

Thank you.

The Chair: Thank you very much for our presentation. There is no time for questions, but we thank you very much.

CAREWATCH SARNIA-LAMBTON

The Chair: The next is Carewatch Sarnia-Lambton; four presenters. There's a fifth person. You're all welcome. We need one extra chair there. There will be, I believe, 15 minutes total for all of you. You can start whenever you're ready. Good afternoon.

Ms. Marilyn Cliche: Good afternoon. Mr. Chairman and members of the committee, thank you for the opportunity to present our concerns with respect to Bill 36, a piece of proposed legislation. The proposed legislation does in fact provide control throughout a locally centralized health care system by government regulation. This legislation explicitly defines LHINs as an agent of the crown which will act on behalf of the government. The governing body of the board of directors will be appointed by cabinet. As you know, the minister will have significant control inclusive of accountability agreements and funding allocation, and all 14 LHINs must develop their plans in accordance with the timing and framework as set out by the minister.

When the Liberal government was elected, we the people were promised transparency and accountability. The level of control this minister will have over our health services, we believe, is not in keeping with this promise. The legislation does not appear to provide for democratic control or public input, and the public has not been adequately informed with respect to the managerial details of this legislation. However, we do note that the

legislation provides indemnification for everyone but the service providers.

Without having been passed, albeit through second reading, LHINs management and some staff have been retained by the government, and office space, equipment and protocols appear to be in place, without the full implications and costs of establishing yet another bureaucracy being known.

In our opinion, democratic control, public input, public notice and principles need to be addressed. Provisions for communities to appeal and requirements for public notice must also be met. The legislation provides unprecedented powers to the minister and cabinet to completely restructure the delivery of health services, including the power to turn delivery of services from non-profit over to for-profit corporations.

In spite of the so-called accountability agreements to allocate funding, the legislation is wide-scoping and broad, and we are concerned with the basic definitions found under subsection 2(1) and clause 25(1)(a), in particular “‘integrate’ includes.” The minister and LHINs are given extreme powers to order any non-profit health service that receives funding to close or amalgamate non-profit health service providers, of which we have three in our community; transfer all of the operations of any non-profit health service providers from one to the other or to a for-profit corporation, including but not limited to clinical services; issue compulsory integration decisions, co-ordinating services, creating partnerships with other persons or entities, whether public or private, not-for-profit or for-profit, and so forth.

LHINs have been given the power to veto voluntary integration and agreements under section 27(1) and transfer those services to another person or entity. Restructuring of this magnitude, we believe, may also create many expensive legal issues and challenges.

There is nothing in this legislation to prevent: immediate cuts in all clinical and non-clinical service areas; overcharging of services, exorbitant costs and out-of-pocket expenses to be incurred by consumers; and time limits for patients' travel or services and/or refusal of services, therefore driving the public to seek out private care, which many will be unable to afford. It appears to promote privatization and allow hastened managed, competitive bidding throughout the entire system, and it appears there is no protection of public health. We are gravely concerned about this plan.

As mentioned, each individual LHIN—there will be no requirement for consistency in accountability. Accountability agreements, confidentiality agreements, terms and conditions of those agreements, access to equal care, co-ordination of the level of care and services will all be at the minister's discretion. We respectfully request an amendment to the legislation with language that clearly set out the terms and conditions for all LHINs with respect to accountability agreements. We must have equal and pan-provincial accountability.

We also note that our physicians have been excluded from this legislation. Why? I live in LHIN area 1. My

physician and dentist are in another geographic LHIN area. Should I have a medical emergency, I can say without reservation that I want and expect my personal physician of 18 years involved in my immediate medical care. He should have the right and authority to medically intervene on my behalf, give instruction to a LHIN 1 ER physician and have the authority to transfer my care to another facility. We hereby request that the legislation be amended to include physicians, dentists and dental surgeons as primary service providers.

Although the Canada Health Act calls for accessibility and universality in public administration, the managed competitive bidding system for health services will, in all likelihood, result in fewer hospitals providing services and, based on age and growth population statistics, create greater inequalities in local access to health services. Patients will become nothing short of inventory. Profit is profit, and that is what patients will be reduced to: inventory.

All one needs to do is look at the anti-trust hearings currently taking place in the United States with respect to integrated health networks and the profit and corruption they have created. In fact, the US is facing the same wait times dilemma and staff shortages that we in Ontario are experiencing. So, does an integrated health network really solve health care problems?

Will the LHINs really be accountable to the public they are supposed to serve, or only to the health minister and cabinet? Is it being created to act as a buffer between the people of the province and the government, or is it being established as a monetary scheme similar to the integrated health networks in the United States? What is the actual cost of funding the LHINs? How many people will they employ, at what salary levels? Will the LHINs, to create a cloak of secrecy, simply amend their bylaws, which they are entitled to do under this legislation? How will privacy legislation affect the public's right to know, with respect to this legislation and the operation of the LHINs? Too many questions are unanswered. The public requires and is entitled to full disclosure.

We're also concerned with the word “entity,” which appears in this legislation. In particular, we take notice of “entity” meaning a person who operates under the Public Hospitals Act or the Private Hospitals Act.

There is no exclusion provision for a Shriners hospital. Why? If the children in our province requiring specialized burn or orthopaedic care should ever be fortunate enough to benefit from a Shriners hospital, the members of our group, who are wives of Shriners and raise the money, believe that this government should take an absolute hands-off approach and provide an exclusion in this regard.

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Additionally, Carewatch continually receives telephone calls from patients in our area, and we visit homes of people in our community to assist them in receiving the level of care they are entitled to receive under the ministry guidelines. Prior to the establishment of CCACs, a physician and discharge planner determined the level of

care a patient would require upon returning home. As a result of previous health care amendments, patients are subjected to dealing with persons unknown. We have a concern that the sustainability program between the Ministry of Health and the CCACs will again be implemented. We do not want to see for-profit nursing homes being permitted to be subsidized by the government for an 80% bed level capacity. It cannot happen. We cannot have the CCAC dumping our seniors into any for-profit nursing home to sustain an 80% bed level capacity in order to receive funding from the ministry through the LHINs.

Is the government choosing to find itself in a tragic situation? We hope not. We know that inspectors have already been cut from the budgets and we are gravely concerned, as you will note from the pictures in your brief. These are conditions which we found locally in a nursing home. We took the issues to certain elected bodies and persons. Some of the issues have been rectified; some others are still ongoing. Inspectors are a requirement. These are our senior citizens, the people who fought to give us the right to sit before you today. We must take care of our seniors. Inspectors are a necessary requirement. To off-load that service from provincial to a for-profit inspection agency is unacceptable to our seniors, particularly in the Sarnia and county of Lambton area.

We find it sad when the government of the people is not consulting with the people, and by that we mean the actual health care providers—not managers, supervisors, accountants, economists or hospital funding consultants. We mean the women and men who know first-hand the needs of these seniors and the people in our community.

We also have a concern with respect to downloading of funding and where the funding in our local community is coming from and going to. As a Shriner's wife, I can assure you that our local Shriners raised and donated hundreds of thousands of dollars to our hospital for a burn unit. The hospital took the money; there isn't going to be a burn unit. Shriners raised and donated money for a burn unit for our community, which has Chemical Valley. There isn't going to be a burn unit, but the hospital took the money and put it into general revenue. That's unacceptable. Confidentiality agreements have to go. We need accountability.

Our city and county levels of government, as well as taxpayers and community service organizations in Lambton county, have been funding our local health care system. We need to know if Bill 36 will require the citizens of Lambton county to continually subsidize our local health care system. How much more money will this minister expect from the people of Lambton county? Will we have to continue to pay extra money once our hospital is built or after our hospital is built? Our hospital has given out \$1.8 million in interest-free loans, repayable from 2006 to 2010. How will that type of financing, interest-free, affect our funding from the LHINs?

Under the previous government, hospitals were allowed to generate revenue through the bonding pro-

gram, and our hospital is no exception. They have an interest in a joint venture and an interest in a subsidiary corporation. However, the majority of persons associated with these corporations have no affiliation with our community; in fact, two persons are non-residents of Canada and live in the Netherlands. Where is the money coming from and going to?

We are requesting amendments in this legislation that monies coming from the ministry being downloaded into our hospital system or from the LHINs be accounted for. This is your money; this is our money. Whether or not a hospital has a side business, which they are permitted to do, we have a concern that hospitals may incorporate and add subsidiary companies to generate revenue by having all of the non-clinical services themselves. So we're looking for some accountability. Confidentiality agreements need to go, period. This isn't just a separate little corporation; this is everybody's money, everybody's interests in our community.

I think I will leave it at that.

The Chair: You are right on the 15 minutes. Also, I need you to identify yourself. Could I have your name, please?

Ms. Cliche: I'm sorry. My name is Marilyn Cliche.

The Chair: Thank you, Ms. Cliche. We thank all of you, and we do have what you said in writing, so I'm sure the ministry and everybody else will take note. Thank you.

RÉSEAU FRANCO-SANTÉ DU SUD DE L'ONTARIO

The Chair: Our next presentation will be done in French. All of us, I believe, have a translation machine if we need it. I would ask the Réseau franco-santé du Sud de l'Ontario—or close; I didn't take any direction from the assistant here. How good was it? She can speak French.

Bonjour. Bienvenue. That is all I can say in French. I can say a little more than that. But you can start any time you wish. You have 15 minutes total.

M^{me} Marthe Dumont: Monsieur le Président, mesdames et messieurs membres du comité, nous aimerions d'abord vous remercier d'avoir accepté de nous entendre aujourd'hui. La transformation du système de santé ontarien entreprise par le ministre Smitherman et le gouvernement de l'Ontario, et le projet de loi 36 qui en découle, sont d'importance capitale pour les francophones. Ils représentent des occasions pour la minorité franco-ontarienne de prendre la place qui lui revient dans le système de santé transformé.

Permettez-nous d'abord de vous présenter le Réseau franco-santé du Sud de l'Ontario.

Le réseau est un organisme sans but lucratif qui oeuvre à l'amélioration de l'accès aux services de santé en français dans le sud de l'Ontario.

En 2001, un comité consultatif a déposé à Santé Canada un rapport sur la question des services de santé en français pour les francophones hors Québec. Les

résultats font réfléchir: 55 % des francophones en situation minoritaire au Canada n'ont pas accès à des services de santé en français.

Cela a mené à la création de la Société Santé en français, puis en 2003 de 16 réseaux au Canada, dont le Réseau franco-santé du Sud de l'Ontario. Le réseau a tenu son assemblée de fondation le 23 avril dernier.

Le Réseau franco-santé du Sud de l'Ontario vise une concertation des forces vives du milieu pour améliorer, en bout de ligne, la santé des francophones. Le réseau regroupe donc différents intervenants dans les domaines de la santé et de la francophonie, dont des professionnels de la santé, des établissements de santé, des organismes communautaires francophones, des établissements de formation postsecondaire, des membres de la communauté francophone, des autorités gouvernementales et d'autres partenaires. Il compte jusqu'à présent plus de 140 membres individuels ou corporatifs.

Le réseau dessert un vaste territoire qui s'étend de Penetanguishene au nord jusqu'à Welland au sud et de Peterborough à l'est jusqu'à Windsor à l'ouest. Ainsi, le réseau compte sur son territoire 10 des 14 réseaux locaux d'intégration des services de santé.

Le réseau est gouverné par un conseil d'administration formé de neuf bénévoles issus de différents secteurs et milieux.

Le réseau s'est donné comme principaux objectifs : d'être le porte-parole des francophones dans le domaine de la santé auprès des instances gouvernementales et associatives; de promouvoir activement les services de santé en français auprès des membres de la communauté, des intervenants et des organismes de santé; de favoriser l'engagement communautaire; d'établir les partenariats nécessaires dans le but d'assurer l'accomplissement de son mandat, ce qui comprend, entre autres, participer à l'évaluation de la situation des services en français, à la détermination des besoins, à la planification des services et à l'élaboration de stratégies de recrutement et de maintien en poste des professionnels de la santé; d'assurer la mise sur pied d'initiatives francophones pertinentes et d'appuyer, de diverses façons, des projets à l'échelle locale.

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Permettez-nous maintenant de vous dresser un portrait de la communauté franco-ontarienne de l'Ontario et, en particulier, de celle du sud de l'Ontario.

On compte 548 940 francophones en Ontario. Cela équivaut à la population totale de Terre-Neuve et Labrador et à près de quatre fois celle de l'Île-du-Prince-Édouard. Dans le sud de l'Ontario, on trouve près du tiers de tous les francophones en Ontario, soit 174 870 francophones. Près de 65 % des francophones sont nés en Ontario, près de 25 % au Québec et 5 % à l'extérieur du pays.

Le deuxième rapport sur la santé des francophones de l'Ontario révèle que les francophones en Ontario sont, en proportion, plus nombreux que les anglophones à se percevoir en moins bonne santé. Ils ont obtenu un score plus faible sur l'indice de l'état de santé fonctionnel.

Le taux d'usage quotidien du tabac parmi les francophones à faible revenu familial est deux fois plus élevé que le taux de l'ensemble de la population.

Il y a une plus grande proportion de francophones que d'anglophones qui souffrent de maladies cardiaques. Les femmes francophones sont plus portées à souffrir de maladies cardiaques que les femmes anglophones.

Suivant l'adoption de la Loi sur les services en français en 1986, les conseils régionaux de santé ont identifié 172 organismes de santé pour offrir des services de santé en français dans le sud de l'Ontario. Or, ces organismes, dans les meilleurs des cas, offrent à l'occasion seulement des services très limités de santé en français. De plus, de ces 172 organismes, neuf seulement ont demandé et obtenu une désignation totale ou partielle en vertu de la LSF. Cependant, il n'existe aucun mécanisme pour vérifier que ces organismes offrent véritablement des services de qualité dans les deux langues officielles, après leur désignation.

Les seuls services sur lesquels nous pouvons vraiment compter sont ceux des deux centres de santé communautaires francophones. Malheureusement, ces centres offrent uniquement des soins de santé primaires et ne peuvent desservir à eux seuls l'ensemble du territoire qui est le sud de l'Ontario.

Lors de l'adoption de la Loi sur les services en français, les francophones ont fondé beaucoup d'espoir et ont travaillé avec le gouvernement Peterson afin de mettre en place des services qui leur permettent de protéger leur langue et leur culture. Vingt ans plus tard, ils n'ont toujours pas accès à des services adéquats en français. Presque partout dans la province, la qualité et l'accessibilité des services en français ont dégradé. La communauté franco-ontarienne n'a pas été protégée.

M^{me} Nicole Rauzon-Wright: Jusqu'à maintenant, la prestation de services de santé en français a été laissée au bon vouloir des organismes. Il n'y avait aucune mesure de rendement, aucune mesure incitative, aucun mécanisme de responsabilisation. Voici donc quelques exemples pour illustrer la situation des francophones en Ontario.

(1) Dans le sud de l'Ontario récemment, une adolescente dont la mère est victime de violence est traumatisée par la situation familiale. Ces deux femmes sont seules, sans soutien familial, leur deuxième langue est le français, et elles ne comprennent pas un mot d'anglais.

Alors que des services en français sont à la disposition de la mère auprès du centre d'aide aux victimes de violence sexuelle, aucun service n'existe pour venir en aide à cette jeune fille en français.

Au fil des semaines, la situation s'aggrave. La jeune fille perd du poids. Elle est déprimée. Elle ne veut plus aller à l'école et se replie sur elle-même. Le psychologue anglophone, provenant d'une culture qui accepte la violence, ne peut communiquer avec elle et ne lui offre aucune sympathie.

La mère est désespérée. Elle ne sait vraiment plus comment se sortir de cette situation. En plus d'être pauvre et violentée, elle ne peut aider son enfant.

Tous les efforts pour trouver des services pour venir en aide à la jeune fille se sont soldés par un "Sorry."

This would be unthinkable in English. Why is it acceptable in French?

(2) Ailleurs dans le sud, une dame nouvellement arrivée du Québec, lors d'une consultation, apprend de la bouche d'un anglophone qu'elle a le cancer. La dame panique, ne comprend rien et croit qu'elle va mourir. Il n'y a personne autour pour la rassurer et lui expliquer la situation dans sa langue. On cherche partout dans l'hôpital pour trouver finalement une personne capable de lui parler dans sa langue et lui expliquer les démarches à suivre.

Just picture a person you care for being in this kind of situation, with absolutely no help.

(3) Cancer centres are being expanded and new ones are built across the province, and until we brought the bilingual situation to the attention of Cancer Care Ontario, nobody had thought about the provision of services in French.

Here in London, the cancer centre welcomes new patients with orientation material and a calendar for treatment follow-ups. There are great tools for the English-speaking patients; however, French-speaking patients are given an outdated, 10 years or more, French orientation text, with only an English calendar. The sad thing is that there is money that could be used to translate and update the French through special funds that in no way would have affected the budget of the hospital.

Furthermore, the only services available in French are those of the receptionist, even though there's a sign posted at one of the clinics stating that services are offered in both official languages. Accountability is essential. We must work together to fix situations like this one.

Ailleurs dans le sud, une enfant d'à peine trois ans doit subir une intervention chirurgicale dans un hôpital identifié, dans une région à forte concentration de francophones. Malheur, elle ne comprend pas ce qui lui arrive et aucun membre du personnel ne peut la réconforter et lui expliquer la situation.

Picture yourself as a parent watching helplessly your terrified child crying her way to surgery. Would you accept that situation if the roles were reversed?

En terminant, l'exemple sans doute le plus explicite : une personne se présente à l'urgence en se plaignant d'avoir mal au coeur. « J'ai mal au coeur » can be literally translated as, "My heart is aching." So heart professionals start the whole intervention, thinking they're dealing with a heart attack victim. This time, the patient had an upset stomach.

As funding members of this country, the Franco-Ontarian minority do not wish to be considered an afterthought or cause the system undue expenses. The community wants to work with you. It believes that French-language health care services are part of the solution, not the problem.

Toutes les décisions qui touchent la planification et la prestation de services de santé en français à la com-

munauté franco-ontarienne doivent être prises par la communauté franco-ontarienne. C'est non seulement une question de meilleure pratique, c'est aussi une question d'équité, de droit. Il doit donc y avoir une reconnaissance du rôle de la minorité franco-ontarienne à cet égard.

Il est important de comprendre que la communauté franco-ontarienne n'aspire pas à un système de santé séparé. Elle recherche plutôt un moyen d'intégrer le système de santé transformé de façon à répondre aux besoins et aux attentes de la communauté franco-ontarienne.

La minorité franco-ontarienne et la majorité anglophone ont des statuts et des droits égaux comme peuples fondateurs de ce pays. Ils ont droit à un accès égal à des services de santé dans leur langue.

Les RLISS doivent en tout temps agir dans l'intérêt public. Ils ne peuvent pas prendre de décisions qui causent des torts irréparables à la communauté franco-ontarienne. C'est pourquoi il est indispensable de rendre responsables les RLISS et les pourvoyeurs de services de la prestation de services de santé en français de qualité par la mise en place d'ententes d'obligation de rendre des comptes.

How can we help you to ensure that there is accountability for integration and sustainability for quality French services in health? We're looking forward to working with you for the better health of all Ontarians.

Thank you for allowing us to express our views. We welcome your questions.

The Chair: Merci beaucoup for your presentation. There is about a minute left. Why don't we give you 30 seconds each if you want to ask a question? We'll start with Mr. Jackson. Thirty seconds, please.

Mr. Cameron Jackson: You are concerned, clearly, that the French Language Services Act of 1986 will not override any other concerns in this legislation. Or are you looking for something in the legislation that sets out those rights that you currently are entitled to?

M^{me} Rauzon-Wright: We're actually looking for something in the legislation. As the LHINs are being formed throughout the province, although we acknowledge that a few French-speaking people have been appointed to certain LHINs, we certainly don't have full representation. In the south of Ontario, we have 10 of the 14 LHINs, so we need to have something quite spelled out.

Mr. Cameron Jackson: I thought you said nine in your presentation.

M^{me} Rauzon-Wright: No, 10.

M^{me} Martel: Merci d'être venue cet après-midi. J'ai vu à la première page que vous dites : « Ils représentent des occasions pour la minorité franco-ontarienne de prendre la place qui lui revient dans le système de santé transformé. » Mais j'ai vu le projet de loi. À mon avis, il n'existe rien qui va non seulement protéger les services qui existent pour les francophones en ce moment ou améliorer la situation pour la plupart des francophones qui habitent en Ontario. Alors, qu'est-ce que vous voulez

voir dans ce projet de loi qui peut vraiment améliorer la situation?

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M^{me} Rauzon-Wright: On a beaucoup lu le projet de loi. Pour la première fois dans un projet de loi—corrigez-moi si j'ai tort—on fait mention de la Loi sur les services en français. À ma connaissance, 25 ans en Ontario, je n'avais jamais vu ça. Alors, on est content qu'on reconnaisse, qu'on parle dans le projet de loi des services de santé en français. On voudrait qu'il y ait dans le projet de loi quelque chose qui garantisse à la francophonie un droit de regard sur ce qui va se passer. Puis on veut travailler en partenariat avec les autres personnes de la province.

M. Ramal: Merci pour votre présentation. Je pense que c'est vrai, c'est plus important pour notre ministre et ministère que chaque personne qui habite en Ontario tiennent les services en français, en anglais, parce que notre ministre ouvre le dialogue avec la communauté francophone à travers la province pour établir un mécanisme pour bien servir chaque personne qui habite en Ontario.

M^{me} Rauzon-Wright: Oui. J'ai siégé sur un comité consultatif de M. Smitherman, ce qui fait que je suis au courant. On a soumis un rapport qui devrait sortir bientôt.

The Chair: Merci beaucoup for your presentation. We thank you again.

LONDON HEALTH COALITION

The Chair: The next presentation will be the London Health Coalition. Is someone from the London Health Coalition here? Good afternoon. You can start any time you're ready, gentlemen.

Mr. Peter Bergmanis: Good afternoon. I'll introduce myself. I'm Peter Bergmanis. I'm the co-chair of the London Health Coalition. The London Health Coalition is a chapter of the Ontario Health Coalition, from which I believe the committee has already heard a brief. The gentleman beside me is Jim Reid, a member of our chapter here in London as well as a representative of the Local 27 CAW.

At the core, this bill is essentially a health restructuring act vesting the Minister of Health with unprecedented powers designed to facilitate the restructuring of health care in the province. Unfortunately, the legislation as currently constituted contains few, if any, democratic checks and balances to ensure that population need and the principles of the Canada Health Act are paramount.

The health care system of Ontario has been in perpetual turmoil since the 1990s. During its tenure, the hospital service restructuring commission ordered the amalgamation of 45 hospitals into 13 and closed 29 hospital sites. Hospitals were thrown into a state of chaos, experiencing forced amalgamations, bed closures, staffing cuts, emergency room overcrowding and serious backlogs for clinical procedures and diagnostic tests. London's health care institutions were no exception. They were shrunk down to only two. Today, those would be St. Joseph's Health Care and the London Health

Sciences Centre. The St. Thomas Psychiatric Hospital and the London Psychiatric Hospital were both ordered closed. Emergency services have been transferred to only two sites: the Westminster and University campuses of London Health Sciences.

Forced to comply with the unrelenting demands of restructuring, and without commensurate funding support from Queen's Park, hospitals have been drained of their financial reserves. To this day, hospital restructuring costs continue to mushroom, without provincial guarantees to assume operating costs that have incurred. London's hospitals are millions in debt. Another costly round of restructuring will do little to alleviate their current financial plight, much less any further financial woes.

Furthermore, the term "local health integration network" is actually quite misleading. There is very little local or integrated about the entire model. As previously noted, the LHINs legislation is a health restructuring act, centralizing more powers than during any other restructuring in the history of Ontario's health care system. Rather than moving decisions closer to communities, real power will reside with the health minister and cabinet. The repository of new powers will include: the ability to transform or order services, personnel, property and funding with limited compensation or opportunity to appeal; the ability to order the closure, merging and transfer of all operations of any non-profit service provider; a new structure for the health system established unilaterally by the health minister's strategic plan; enforcement of these new powers by court order.

The scope of the legislation encompasses all hospitals, some mental health facilities, charitable homes for the aged, community health centres and a host of government-funded health service agencies. Glaringly, doctors, private diagnostic clinics and labs are excluded. It is telling that legislation which purports to integrate, improve case management and provide a seamless continuum of care somehow ignores the system's key players.

Bill 36 also suffers from a real democratic deficit. There are no traditional democratic checks and processes set out in the legislation. LHIN boards are appointed by cabinet and exist at cabinet's pleasure. Cabinet is endowed with the inexplicable power to exclude any persons or classes of persons from LHIN membership. Yet the qualifications for board membership are decidedly tipped in favour of business and administrative elites, with no corresponding prevention of a revolving door adjoining membership in the for-profit health industry and the LHINs. An overly cozy relationship with the for-profits can open the door to potential scandal.

The LHINs are yet to be up and running, yet problems with how their membership is constituted are already emerging. The newly appointed chair of the South West Local Health Integration Network, Tony Woolgar, comes from the United Kingdom under a cloud of allegations of financial impropriety and claims of "cultivating a culture of fear." This is from the Bristol Evening Post, dated

back in October 2003. Evidently, the LHIN's exclusionary clause does not apply to anyone of the calibre of Mr. Woolgar.

The bill contains no protections against secret, in camera meetings of the LHIN board, no public process for access to timely information regarding restructuring proposals, and no process for public input or appeal. In effect, the very people the health system was designed to serve—patients—are shut out.

With the lack of proper democratic oversight, the threat of privatization intensifies. The legislation facilitates privatization in several ways: The LHINs are endowed by the Minister of Health with the power to move funding, services, employees and some property from non-profits to for-profits, not the other way around; cabinet may order the wholesale privatization or contracting out of all support services in hospitals; the minister may close or amalgamate non-profits—again, the exclusion of the for-profit sector from such draconian measures fuels new market opportunities as the numbers of non-profit providers shrink; there is no prohibition against delisting of OHIP services, leaving people at the mercy of out-of-pocket expenses for services which the for-profits will be all too eager to provide and charge for at a handsome cost.

Again, no discussion of forced privatization of a public service like health care would be complete without mention of the introduction of market competition. Under the guise of the wait time strategy, the McGuinty government has elevated market competition to a whole new order of magnitude. The same devastating policy for which the previous Conservative government was blamed for destroying home care, the McGuinty Liberals are now prepared to unleash upon the hospital sector. That would be competitive bidding. Under this model, a pricing system is created, and services such as cataract surgeries are tendered for bid to health care providers, both profit and non-profit. The provider that bids under the government-set target price wins the contract. Government funding would flow to the successful bidder.

Such pricing and competition regimes are fraught with pitfalls: administrative inefficiencies which suck money away from patient care; competition fragments providers, converting colleagues into competitors. Results include constant personnel turnover, lack of continuity of care, low wages, a shortage of skilled workers, high costs, and an ever-increasing shift to for-profit delivery. Consolidation of services into specialty hospitals undermines the efforts of civic-minded citizens and leaders who have worked hard to improve local access to services.

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London, as a major centre, may fare well under such a regime, but when the enormous geographic size of a LHIN that stretches from Tobermory to Long Point is considered, how onerous will it become for patients requiring to travel further in order to access health care services? Loss of local accessibility will only exacerbate inequalities of access to care, since some individuals would not have the means to travel long distances.

To conclude, Bill 36, as constituted, poses an enormous threat to the survival of the public health care system Ontarians cherish. An unprecedented power shift into the hands of the Minister of Health without any corresponding democratic checks and balances belies the true intent of this legislation, which would be forced health restructuring driven by cost containment and not patient care needs.

Not only does the government risk another expensive restructuring boondoggle, whatever cost savings may be enjoyed are questionable. Additional tiers of administration from the LHINs onto the hospital oversight of private contractors will be added on without any benefit to bedside patient care. A workforce without stable, long-term job security, forced to seek alternative employment, would leave the high-stress environment of the public system, further contributing to the erosion of medicare. Demoralized health care providers cannot deliver top-notch quality care.

The increased incursion of transnational, for-profit health care corporations will open medicare to challenges under trade agreements, which could forever change the health care landscape of Canada. Ontario is in danger of degenerating into the morass facing the National Health Service of the United Kingdom, rife with its scandals and hospital closures due to the introduction of market forces.

In the opinion of the London Health Coalition, at best, Bill 36 should be scrapped. At the very least, the most odious elements of the legislation should be revamped. Real democracy, proper safeguards for public accountability, stakeholder participation, and commitment to the overriding principles of the Canada Health Act need to be carved into this flawed legislation. Ontarians deserve no less.

With that I submit my brief and invite the panel for any questions.

The Chair: Thank you. We have about three minutes. I'll start with Madame Martel, please. One minute each.

Ms. Martel: Thank you for being here today. My first question is this. In light of some of the information that you've provided in the brief and that we've heard before about the democratic deficit—i.e., members of the LHINs being appointed by the government, serving at the behest of the government; that the LHINs themselves in the legislation appear as agents of the government; that there's nothing in the legislation that talks about how the community will be engaged in any concrete term; that the board members themselves only have to sit four times a year, etc.—how confident are you that the community interests are really going to be served under that kind of framework and that kind of set-up?

Mr. Jim Reid: One of the concerns that we see with the legislation is that it duplicates the oversight of hospital boards. We won't see the ability of local communities, especially outside major health care centres like London, to have any input into the process of how health care is delivered in their local communities. The duplication of the administration: At this point in time, the province has spent over \$40 million to set this process up

and it's not benefiting one patient in the province. The problem that we're going to get into here, quite honestly, is that without that local oversight, we're going to end up with everything that the right wing complained about the medicare system in the United States: that it's a top-down bureaucracy. Here, we've concentrated the control in the hands of the minister, with a few designated sub-lieutenants across the province who are going to dictate how health care is delivered in local communities. That is a significant issue that I see across the province.

The Chair: Mr. Ramal.

Mr. Ramal: Thank you for coming and telling us about your concerns. I share your fear about the government, especially from experience with the past government. When they tried to reconstruct health care, they closed a lot of hospitals; they closed a lot of facilities across the province of Ontario. But don't you think that yesterday the Minister of Health, in his opening statement, was very clear in terms of two-tiered health care and hospital closures that clearly, to all the people in the province of Ontario, he is against closure; no two-tiered health care in the province of Ontario?

Mr. Reid: What we've got is privatization from the inside out. That's what this legislation effectively is: It's privatization from the inside out, at least speaking on behalf of the workers I represent in the two major hospitals in London. We're seeing non-clinical services—and basically, these are fast-tracked and wholesale changes that are going to be allowed to turn over the work and the services that those workers provide to the private sector. So really, what we're seeing are not the cut-and-slash policies of the previous government; what we're seeing is the slow erosion of the health care system by this government. This is part of this legislation, and I believe that this is part of the overall plan by the Liberal government in Ontario: to erode public access to the health care system.

The Chair: Mr. Jackson.

Mr. Cameron Jackson: Thank you for your presentation. You have a working knowledge of some of the other legislation. One of the concerns I have about the net effect of this bill is that, in terms of the role for MPPs raising questions, it's going to be very hard for us to raise health care questions in the Legislature, and I'll tell you why. This legislation is constructed in the same context as workers' compensation legislation, and I recall that because I used to work at Queen's Park when it was being constructed. Essentially, it says that if there's this agency out there that's responsible for injured workers, you can't ask the minister a question on the floor of the Legislature because there is this arm's-length agency that deals with it.

My worry here—and I think you've been alluding to it—is not only the lack of transparency, the confidentiality agreements, the gag orders on talking to the media; it's that, even as MPPs, we're not going to be able to raise specific questions, because the minister will be able to say, "Look, that's not my responsibility. I've given them their envelope. That's what they manage.

They're accountable." If he's going to end up saying that, where is the true accountability? I see this as a huge loss for the last voice you have at Queen's Park, which is the person you elected to go there and speak up for you. Even that is being taken away in this legislation because of the manner in which it's scheduled. That's the technical word we use in legislative terms for an agency that is scheduled, which determines how much you can discuss it on the floor of the Legislature.

Mr. Reid: We're on that same page. Obviously a LHIN can act as a bulwark against any kind of political flak that may come from decisions that the minister may take, or that the LHIN board may take because they're at arm's length, as you note. Then all of the consequences or any political fallout will just fall on them.

The Chair: Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 260

The Chair: We'll move on to the next group, and that is the Ontario Public Service Employees Union, Local 260, Markdale. You can start anytime, madam.

Ms. McIlwraith: My name is Jill McIlwraith and I have been an RPN working in Ontario's health care system for the past 32 years. I am currently president of OPSEU Local 260, Grey Bruce Health Services, in the South West LHIN. I represent 934 health care workers in an amalgamation of six hospitals. I also sit as an executive on the health care divisional council and as chair of the health care support sector.

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In 1998, under Bill 136, our six hospitals voluntarily amalgamated to form the current corporation. Before the hospital cutbacks in the 1990s, our six hospitals had a total of 800 beds; our current corporation has 140 beds. Long-term care was removed from our hospitals, as well as a complex long-term-care unit which took care of patients who were not requiring an acute hospital bed but did need care above a level that could be provided in a nursing home. The replacement beds were not put into the communities to cover the number of beds that were closed. This has had a major impact on wait times in our region, as more than 50% of our medical beds are taken up by patients who are awaiting placement in a long-term-care facility.

Under our amalgamation, the board of the corporation has attempted to move services around within our communities. This has been met with strong resistance from the doctors and surgeons providing these services, who did not want to move to a different town to practise in their field of expertise. Under the restructuring of the LHIN, we may lose many of the professional services, and the doctors and health professionals who provide these services, if they are relocated from one area to another. We cannot afford to lose any doctors or professionals from our area, as we are already facing a critical shortage.

What of the impact on the patient and their family? Who pays for flights, hotels and time off work to assist patients to travel to distant cities for treatment? For those who cannot afford these expenses, we are creating a two-tier system. What is the difference between charging user fees and creating conditions whereby access to health care is dependent on high personal expense?

If services are to be moved out of our area, then what is the impact on the employees? Workers are not always as portable as the government would like to believe. Two-income families are often faced with a dilemma when the workplace for one is suddenly shifted to a location hundreds of kilometres away.

The impact on employees during the restructuring of the new amalgamation was very stressful, as bargaining agents had to vie for representation rights. It left most employees feeling uncertain as to the role they would have in a much larger workplace than they had originally been hired for. There have been layoffs every year in the past six years, and job security has become a thing of the past to most of the employees of GBHS. Workers are tired of all the changes. When workers feel under threat of job loss or major change, morale plummets. This can't help but have an effect on patient care. Health care support workers are a very dedicated group of people. In our smaller communities, we take pride in the work that we perform and the services to our fellow community members.

During the same period of this restructuring, while front-line workers were reduced in proportion to the bed reduction, there was no comparable reduction in management personnel. More managers now direct fewer workers. Might I be so bold as to suggest the possibility of significant cost savings potential going unaddressed?

We now have the food that we feed our patients outsourced. While we are assured that it is nutritionally complete, I would have to doubt that a patient is getting the proper nutrition when many meals are returned to the kitchen uneaten, as the food is unpalatable to ill or elderly patients. It is unpalatable to relatively healthy people, and only those with a strong constitution and well-anchored teeth are able to consume it. We cannot understand why non-clinical services are being targeted by the government under section 33 of the bill.

Dietary and building maintenance are inherent parts of the health care system. Other health systems have made these services the focus of privatization and restraint, creating more hospital-borne infections and increasing the likelihood of the transmission of viruses in the health care environment. The issue of hospital infection has been well documented in our media, yet the LHIN restructuring thinks that a private, for-profit service would be able to do an adequate job. Our staff have been well trained and know the necessity of keeping a high-level watch on the hygiene of our buildings, with the ever-present germs that live in a hospital.

Our staff take pride in their work, but their numbers have been cut so much that it is a battle that is not always won in controlling the spread of infection. I do not

believe that a third-party, for-profit company taking over the responsibility of maintaining the cleanliness of our hospitals is going to do as well as the dedicated staff who now do it. It is another case where the government's idea of integration is contrary to the good functioning of the health system. The added stress of having to compete for your job every time the competitive bidding process is renewed can only result in less focus on the job for the employees.

Five of our six hospitals had no deficit at the time of our amalgamation. Now we all enjoy a yearly deficit and the most common topic is budget: How can we trim more from supplies; how can we do more work with fewer people? There has been no financial advantage to our amalgamation, and if the hospital is believed, the ministry did not take into consideration the vast distances between our sites, there being more than a 100-kilometre spread from one end to the other. Our LHIN has a major centre, the city of London, but we are at the opposite end and need to have our rural issues addressed. While it may be efficient from a delivery standpoint, it is not efficient from a user standpoint. Again, who pays for flights, hotels and time off work to assist patients to travel to distant cities? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on high personal expense?

We will see fewer nurses, fewer MRI technologists, fewer cleaning staff, fewer pharmacy technicians, fewer RPNs, fewer dietary staff and fewer clerical workers. Smaller communities and medium-sized ones will likely lose those services. In most of our communities, the hospital is the largest employer. There would be an impact on our communities by further downsizing or the privatization of our services, leading to economic loss. Our small towns and businesses depend on having our services close to home.

Patients will have to travel further. In our counties, winter travel is not always an option, and we do not have the necessary public transit. It simply does not exist. Under fiscal pressure from the government, the LHINs could very well rationalize many health care services under the integration plan, forcing patients to travel hundreds of kilometres for services we presently receive in our local community.

The local health integration networks are being presented as the solution to problems in our health care system. Ontario's health care system is not broken and does not need such a massive and costly reorganization. In fact, the risks outweigh any potential we can reasonably see that would emerge from this restructuring.

The real cost drivers in the system are not addressed by this reorganization. For example, pharmaceutical costs made up 16.7% of health expenditures in 2004. Drugs costs are the fastest-growing expenditure in health care, yet pharmaceuticals are left out of this structure. The large number of P3 hospitals the government has embarked upon also poses a serious threat to future health care funding, as does the rising cost of equipment.

We have been waiting for approval of a new hospital in our amalgamation. The community raised its portion

of the money, \$13 million, and we have not yet heard if we can go ahead with it.

Lacking in the LHINs legislation is any real human resources strategy. I wrote the report on the human resources issue for the South West LHIN. One point that was clear with all the stakeholders I had contact with during the information gathering for that report was that a human resources plan was needed and should be put in place before any restructuring begins. While the rules do provide a forum for unions to battle out representation issues, the process is going to create retention and recruitment problems. We already face difficulties in recruiting health care professionals in small rural areas. Speculation about amalgamations and transfers is going to enhance the existing problems of bringing needed health professionals to our communities. Who is going to relocate to a more remote community when the likelihood of having the service transferred to another centre is rumoured or imminent?

The province needs to develop human resource adjustment plans, taking into account existing collective agreement language where applicable. It should also be willing to substantially fund these plans. Human resources plans will need to be negotiated, and will need to include, at a minimum, retention and recruitment policies, layoffs as a last resort, measures to avoid layoffs, voluntary exit opportunities, early retirement options, pension bridging and retraining options. A transitional fund should be put in place and a health service training and adjustment panel should be convened. No legislation should go forward without a human resources plan. Without health care workers, you have no health care system.

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The Chair: There's about minute and a half left. I'll start with Mr. Fonseca; 30 seconds, please.

Mr. Peter Fonseca (Mississauga East): Thank you very much. Jill, I understand your concerns, and I believe that actions speak louder than words. The previous government, as you said, closed hospitals, fired nurses, downloaded public health to our municipalities, mismanaged SARS. There's such a long list against the previous government in terms of what they did to our health care system.

Let's look at the actions since we've come to government and what we've done as a government under Minister Smitherman. He has driven health care into the community; he has put \$260 million more into home care and community support services; he has uploaded public health to the province; he has hired over 4,000 new nurses; we have funded the health care system by more than \$5 billion. All these actions by Minister Smitherman over the last two years are about bringing health care to the local community and making sure we have the best health care system possible.

The LHINs are an evolution in making our health care system sustainable and better for all Ontarians for the future.

The Chair: Thank you. Mr. Jackson, please.

Ms. McIlwraith: Was there a question there? I'd like to respond.

Mr. Fonseca: The question—

The Chair: Excuse me. Anyone has the option to make a statement or ask a question. Because of the time limit, I was going to go to Mr. Jackson. You can answer as you please.

Mr. Cameron Jackson: Thank you, Mr. Chairman. I will yield my moment to the deputant, and she can respond.

Ms. McIlwraith: The cutbacks I'm talking about did not happen under the previous government; they happened under George Smitherman. I am talking about a year and a half ago, when the complex care unit was closed but nothing was put in our community. I keep hearing statements about health care going to the community. I've looked in the phone book, and that community is not there. Nobody is there taking care of those patients when they go out. There has been no increase in funding there; there has been nothing. I come from a rural area. We don't see it. I can't say I wholly blame the last government—yes, they did a lot—but this government is really riding the same rocket.

The Chair: Madam Martel.

Ms. Martel: I'd like to thank you for coming today and for raising your concerns. It's too bad that the legitimate concerns you raised weren't addressed by the government. For example, why doesn't the legislation include a human resources plan? It is very clear from the definition of what the LHINs can do, and the government and the cabinet, that major restructuring is going to take place. It's going to have a major impact in hospitals, loss of services into the community and those services will not be going into the community after all.

You wrote a report for the LHIN about why this was needed. Nothing appears in the legislation. Do you want to raise with us again your concerns, both as a health care worker and as someone who could be a patient and whose family could be patients, about the fact that there is nothing in this legislation that talks about what's going to happen to all these folks when the chaos starts?

Ms. McIlwraith: We have seen what has happened in the past when chaos hits, again without anything in the legislation. I communicated with almost every stakeholder in this LHIN. It was clear that the first issue was getting human resources, and nothing has been done about it.

The Chair: Thank you for your presentation and for your answers.

LONDON INTERCOMMUNITY HEALTH CENTRE

The Chair: We'll move to the next presentation from the London InterCommunity Health Centre. You can start any time you're ready, madam. You have 15 minutes.

Ms. Michelle Hurtubise: My name is Michelle Hurtubise. I'm the executive director of the London

InterCommunity Health Centre here in London. Although our provincial association is making a presentation on the concerns of community health centres across the province, today I'm focusing on some of our regional issues, which are certainly echoed across the province.

We believe that community health centres play a critical role in fostering health system transformation. We deliver cutting-edge interdisciplinary primary health care, illness prevention, and health promotion services to hundreds of thousands of Ontarians, many of whom face significant barriers in accessing primary health care. Excellence in interdisciplinary health care and support has also led to their identification as a key vehicle for the implementation of municipal/provincial primary health care strategies such as diabetes care. In fact, the diabetes program at the London InterCommunity Health Centre is recognized as a best-practice model for ethnocultural communities by the Canadian Ethnocultural Council as well as a demonstrated cost-effective delivery mechanism for at-risk communities.

Our services improve and sustain individual health outcomes, and result in an overall reduction on the burden to the province of avoidable high-cost acute long-term-care services. This is a community-based program and needs to be nurtured under a community governance model.

Within LHIN 2, there are currently two community health centres, one in London and another in West Lorne, with London having two sites within the community, as well as there also being an aboriginal health access centre with sites in London and Muncey. Within the next three years, there are three more community health centres scheduled to open in Woodstock, St. Thomas and Markdale.

Our review and what I present to you today results in the development of some specific recommendations geared toward either amending or refocusing some key provisions. We see four overarching principles as critical to the success of LHINs and ask the committee to consider Bill 36 through the lens they provide. These principles are: that Ontario requires a culture of health service integration, not merely a system navigation mechanism; that the ongoing and broadly defined "community engagement" by LHINs is the key to achieving true local integration; that a continuum-of-care approach for health service coordination and integration is critical to ensuring that services reach all clients, particularly those facing barriers in accessing services; that the provincial health system standards, including standards for all primary health care models, are necessary to ensure equity in the system and effective planning at the LHIN level and across LHINs.

In terms of Ontario requiring a culture of health service integration and not merely system navigation, we believe that every door is the right door to services. LHINs should facilitate the ongoing dialogue among all levels of care provision through opportunities not limited to the HAPS process. It needs a multi-sector approach grounded in a focus on the broad social determinants of

health: health promotion, education, housing. Integration needs to be properly resourced. CHCs and others have been doing this work for a long time because it's needed for client care, but, like multidisciplinary teamwork, there is a cost to it that needs to be appropriately resourced.

One of our concerns about an approach of system navigation is that many people with multiple and chronic physical and mental health needs require intensive care management within an integrated system. The capacity to perform this function exists with many different types of organizations—home and community care service providers, mental health and addictions and community health centres—and they need to be resourced as such.

We feel strongly that health care providers in various sectors assisting a client to receive the appropriate care they need is the outcome of an effectively coordinated system, not the role of an individual sector, organization or individual. Each has a role to play in the outcome.

One of our main concerns related to the ongoing and broadly defined community engagement is that we think this is critical for any true change. Community cannot be exclusively defined as a health service provider. Client and client group engagement has to be ensured. There needs to be support for ongoing community governance as a method of ensuring rich client and community engagement processes. Integration orders and institutional changes in services need to be undertaken through a filter that ensures that clients are able to access these services and that resources follow clients to new service locations.

Community governance cannot mean governance of all health services by a regional board. For example, we don't support the Quebec model of community governance whereby all health services in a health region, including hospitals and long-term care, are managed by a single board. We believe, in supporting that community base, that it needs to allow a 90-day period, not a 30-day period, to challenge integration orders to allow community-based organizations an opportunity to respond effectively.

Community governance encourages and fosters volunteerism. So to remove this governance model impedes the critical cost-efficient component of this system.

I do have in my written proposal, which I'm not going to review because I wanted to cover some other points, some specific wording related to ensuring that community engagement is a component of the legislation. There is a clause related to that, that no integration order will result in the elimination of community governance structures except where there is a single health service provider with another single health service provider, but that the community governance model is maintained.

We also strongly recommend that "community" be added to the definitions that are there, which includes that all clients receiving services are captured, the residents in a geographic area, and that the full complement of health services providers is part of that process as well.

Within the continuum-of-care approach for health services coordination and integration, we want to ensure

that proximity of services does not necessarily mean duplication. Barriers to access need to be borne in mind to ensure that services reach diverse target populations. A one-way valve provision is needed, and a provision protecting community groups from hospital deficits is needed.

Related to that in terms of some of the items is funding of health service providers, specifically part IV, subsection 19(1): "A local health integration network may provide funding to a health service provider in respect of services ... in or for the geographic area of the network." One of our concerns is the transient nature of many of our clients, particularly in community health centres that span the boundaries. This is a major issue in LHIN 1, where the Grand Bend area CHC is located, but their catchment base and the clients who are accessing the services are predominantly located in LHIN 2. Planning needs to accommodate for that.

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Provincial health care system standards, including standards for all primary health care models, are necessary to ensure equity in the system and effective planning at the LHIN level and across the LHINs.

We recognize that there are certain HR anomalies within the LHIN scope of authority. For example, all other primary care models, except for community health centres, are outside of the financial planning of the LHIN models, which means that our physicians who are employed by us as health service providers are outside that consideration. We are concerned about equity across primary care models within that kind of framework.

We are also concerned, in terms of the representation, that health professionals advisory groups should ensure that there is representation from the different models, and there are specific recommendations related to the clauses in the submission ensuring that that representation is happening both from the health services provider level as well as within the health professionals advisory committee.

We also want to ensure, in terms of the minister's duty to develop a provincial strategic plan, that a subsection should be added that the minister shall engage the public in the development of that health system and consult reports of the Ontario Health Quality Council in preparation for this plan. It should describe the processes and results of the minister's public consultations and highlight the role of the Ontario Health Quality Council reports and recommendations in guiding his policy and planning decisions.

In general, London InterCommunity Health Centre supports the intention behind the local health integration act. We hope this legislation will ensure that the broad determinants of health are taken into consideration in its consultation process, planning and implementation. Every door must be the right door to service. This means that the processes for community engagement need to be broadly defined and include more than just health services providers and organizations. It also means that all models of primary health care need to be included in

the planning process, as well as the communities that they serve. The planning process also needs to ensure a continuum-of-care approach for the coordination and integration to ensure that services reach all clients, particularly those facing barriers in access and services. We are quite concerned that populations facing access barriers are often further marginalized in the planning process that only considers the global population health perspective.

The Chair: Thank you for the presentation. So one minute each. We'll start with Mr. Jackson.

Mr. Cameron Jackson: Michelle, thank you for your presentation. I share your concern about—this is a crude way of putting it—those who are outside the tent and those who are inside the tent. Mental health seems to be the biggest loser here, in particular children's services. Without getting into a lot of the technical stuff—and I appreciate that you've raised a couple of items that we haven't had presented to us—do you have an overarching comment you could share with us with respect to how we can have a truly integrated system if so many are outside of this model that should be patient-focused and case-managed?

Ms. Hurtubise: I think one of the primary concerns related to that is when you're looking at a community consultation process that's only looking at service providers. The clients we serve are not health services providers; they are people who don't have access. So community governance is a critical component in ensuring that those voices are coming forward, a community governance that is reflective of the community it serves, that engages its clients in a planning process. Some of the other references related to human resources planning that ensures that, in particular, the community organizations are not going to have to bear the brunt of hospital deficits within a LHIN planning process are critical.

The Chair: Ms. Martel.

Ms. Martel: I wanted to follow up on the community governance because, frankly, the bill is pretty well void of any kind of framework with respect to how the community is going to be engaged. From my perspective, while the minister on the one hand talks about this being a process to respond to community needs, there's zero in the bill in terms of showing how the community is going to be engaged. Worse, if you look at a number of the provisions, it just really centralizes that control, not bringing it down to the community level. So what kind of ideas do you have around community governance as part of community engagement to really ensure that people are actually going to have some say?

Ms. Hurtubise: I think community health centres are a good model of community governance, where they draw their governance structures from the clients they serve, the communities they serve, on their boards of directors, as well as having part of their planning processes engaging those community groups in that process.

The HAPS process is an example where service providers were engaged—sort of—in terms of, there was

a plan presented but there wasn't a lot of opportunity to, quite honestly, really influence that much. It was presented for feedback rather than in the development of, and I think there need to be mechanisms so that community and community-based groups are involved in developing those plans, and that as part of accountability mechanisms there are plans for how the community is going to be engaged in the planning of health services and the impact on its community.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: I actually want to pick up where Ms. Martel left off, because this was one of the issues I raised with the minister before we embarked on this exercise: whether we could try to draw out from these committee hearings some of the specifics around what some of those mechanisms might be. You've talked about the community health centre model, you've talked about a plan being presented to a community, but what are the mechanisms that you think should be used to engage people in not just giving feedback, but actually being part of developing that plan?

Ms. Hurtubise: One of the pieces is ensuring in the accountability agreements that there are clear expectations that health services providers are engaged in their communities. I think there's a number of mechanisms. Certainly within our centre we use focus groups, we use client surveys, we look at our health outcome data for our clients in developing our programs and services. I think those are all critical pieces that develop that community governance and respond to the community needs of the clients. We have a voice through responding. Our client community council takes a look at quality service issues and provides that feedback. If that's a mechanism in an accountability agreement both within the LHINs and the health services providers, that they are demonstrating those kinds of mechanisms for community voices to be heard, I think that's one step along the way.

The Chair: Thank you very much for your presentation.

ONTARIO HOME CARE ASSOCIATION

The Chair: The next presentation has been cancelled, so we'll go to the 3:30. Is anyone here from the Ontario Home Care Association present? Susan VanderBent is the only name I have. Could we have the name of the other?

Ms. Susan VanderBent: Margaret McAlister.

Good afternoon. Thank you for inviting us today. My name is Sue VanderBent and I'm the executive director of the Ontario Home Care Association and also chair of the Ontario Home and Community Care Council.

The Ontario Home Care Association is an organization of home health and social care service providers. Ontario Home Care Association members provide a range of home care services, including nursing service, home support services, personal care, physiotherapy, occupational therapy, social work, dietetics, speech language therapy and medical equipment in the home.

Ontario Home Care Association members are contracted by all three levels of government, community care access centres, insurance companies, institutions, corporations and private individuals.

The Ontario Home Care Association thanks the standing committee on social affairs for the opportunity to present the Ontario Home Care Association perspective on the LHIN legislation.

Our association has long been a supporter of the transformation agenda and a systems approach to the delivery of health care in Ontario. The ministry's transformation team is to be congratulated on the comprehensive and thorough development of the LHIN system and its support to the new LHIN chairs and CEOs.

My association supports the fact that the proposed local health integration networks will improve patient care by allowing communities to plan and coordinate local services. This move will allow people to receive care at the right place and the right time, increasing access to local providers and home care service provision through realigned community care access centres.

The OHCA is pleased that the legislation requires the LHINs to jointly develop strategies to integrate services using a process of community engagement, thus enabling the emergence of a systems approach to health care. The LHIN legislation supports local citizen engagement and encourages accountable and equitable decision-making related to funding for care needs. Identifying local care priorities, planning for local health services, and integrating and funding local health services are important levers embedded in the legislation to move health care in Ontario into a true systems support for health care.

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We have some recommendations on the legislation. My board supports the stated intent of the legislation that prohibits LHINs from delivering care. The OHCA believes that the success of this made-in-Ontario solution to reorganizing care at the local level will rest on the fact that the LHINs always maintain a focused planning and integrating role.

The board of the OHCA wishes to ensure that an agenda of inclusivity is maintained by the LHINs, ensuring that all service providers, both transfer payment and non-transfer-payment agencies, be at the tables where discussions are held regarding service provision and the creation of integrated service plans. The input of these providers is important and necessary in order to ensure good ongoing care for people in Ontario. Stronger language in the legislation to reinforce this direction would be useful. I point directly to part III, section 16, sub-sections (1) and (3).

OHCA recommends that the LHINs create health advisory committees that are broadly inclusive of all types of professions, stakeholders and sectors. In this way, the LHINs will get the best advice from many different perspectives and avoid recreating silo thinking and silo attitudes.

OHCA recommends LHINs pay particular attention to enhancing the role and value of the home care sector in

supporting the overall goals of the broader health system reform. The LHINs must have clear indicators that measure better transition planning and home care integration. In a few minutes I also want to speak a little bit to a paper that the Ontario Home and Community Care Council presented.

OHCA recommends that the LHIN boards seek out members with a deep appreciation of the role and value of home care service and its important role in the health care system. OHCA is particularly supportive of a broader role for the realigned CCACs. An expanded role will allow the CCACs to take a central place in the LHINs in demonstrating leadership related to the growth of home care. This will support an enhanced home care system in its focused growth as an integral part of the broader health care system at both the local and the provincial levels.

OHCA believes that the government's transformation agenda rests on the need for a strong and stable home and community care system. It is for this reason that the OHCA strongly advises and recommends that the transition team maintain the same careful planning process to ensure a smooth and effective transition and realignment of the CCACs' boundaries within the LHINs.

OHCA recommends that LHINs broadly support the design and development of a chronic disease management continuum based on local population health needs. The home care sector plays a large role in the support and management of individuals who have life-long illnesses. This would also include an end-of-life and palliative care system. Current work by the Canadian Home Care Association national partnership project suggests that home care has a significant role to play in proactive chronic disease management.

From the patient-client perspective, the LHINs will be successful when integration occurs at the point of care. Since structural changes alone will not necessarily lead to seamless care delivery, a results-based accountability system is also needed to support and monitor the effects of transition planning by the LHINs. To support transition planning, the Ontario Home and Community Care Council suggests that we need to identify key system-wide quality processes for information exchange and determine system performance indicators and outcomes. There are very few, if any, areas in Ontario where system-wide key quality processes related to transition planning or system performance outcomes are being tracked or reported. It is essential to the Ontario integration agenda to support and encourage health care providers to communicate with each other across complex organizational boundaries.

The current investment in e-health and electronic information exchange currently under way in the province will be a great support to the integration agenda. However, the Ontario Home and Community Care Association believes that the process of improving communication related to transition planning can begin at the local level prior to the full implementation of electronic systems. Most health care providers understand that in

the present delivery of health care services, it is the consumer who is vulnerable to the lack of coordination and communication between different sectors in the system. The Ontario Home and Community Care Council believes that the key quality processes of routine discharge planning from acute care to primary care and community care must be expanded to examine the need for a new function within the health care system called "transition planning." Transition planning can be defined as the management of a complex, two-way interface between and among institutions and community-based providers. Transition planning is particularly important for those persons of all ages who require ongoing systems support due to long-term mental or social illness.

Strong working relationships between providers and willingness to share timely and relevant information in all parts of the health care system are required to support good transition planning for people. Particular emphasis in transition planning is placed on the need for continuity and quality of information exchange as people receive care and move back and forth through the permeable boundaries of all parts of the health care system. Key quality processes for transition planning between health care providers are necessary. Key quality processes can be defined as those activities which assist organizations in effectively meeting consumer demands and are the basic building blocks of communication between health care providers in the system. The clear articulation of key quality processes in transition planning will shed new light on system performance outcomes such as decreasing unplanned readmissions to acute care for both mental and physical reasons.

Further research work needs to be done to identify outcome measurements which appropriately capture the increased efficiency and effectiveness of the LHIN. The Ontario Home and Community Care Council believes that tracking the movement of specific, identifiable sub-populations of clients may be a useful place to begin to understand how the system can be improved to give more coordinated care. Tracking movements of persons as they seek health care is greatly supported by the current investments in e-health and privacy legislation, which are now underway in Ontario.

In conclusion, the Ontario Home and Community Care Council believes that when specific system performance outcome indicators related to improved communication have been identified, data about current system practice can be measured and baseline levels of system function can be set. Once current baseline data are in place, measurable time targets for system performance improvement can be identified by all service providers. Each health care provider in a LHIN plays an important role in supporting new system performance indicators that are collectively, and not individually, shared and managed.

Annual reporting in a balanced scorecard format would showcase the success of each LHIN as they move toward the achievement of a truly integrated system of care for people at the local level.

The Chair: There's about a minute and a half, so 30 seconds each. Madame Martel, will you start, please?

Ms. Martel: Thank you for your presentation today. I'm not sure I understood the function of the transition planner. I'm assuming that's different from the system navigator proposal that has come to us. Maybe you can just explain the differences to me.

Ms. VanderBent: I'm not sure. Can you be clearer about the question?

Ms. Martel: I know you're not here representing CCACs, but CCAC has talked about a system navigator approach.

Ms. VanderBent: And you're asking what we think about that?

Ms. Martel: You can respond to that to me as well, but I wasn't very clear on what the difference was between that and you—

Ms. VanderBent: And transition planning?

Ms. Martel: Yes. Which would be a transition planner?

Ms. VanderBent: No. I implied that; I wasn't clear.

Ms. Martel: That's my mistake. Sorry.

Ms. VanderBent: That's all right. It is not a noun; it's a verb. Transition planning is the responsibility of a system and should be embedded in the policies, processes and practices of organizations as they help people to move across systems. It should not ever be embedded in one person, because if you give that role to one person, what you do is take away the responsibility of the system to actually look at how it manages its transitions. If I'm sending a person to you as a sending caregiver, I should be very aware of what you need in order to look after that person. I shouldn't have an intermediary to do that work. As the sending caregiver, I should know what you need as the receiving caregiver and make sure my work that I'm sending to you meets your needs, because you're the person who's going to be carrying on the care.

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That's what we do not have, really, in our system at this present time. We send people out from all kinds of organizations, back and forth. People do move back and forth nowadays because they often have chronic or lifelong illnesses. But the sending and receiving of information is not well done, and that's what we have to do better as a system and as a group of providers.

The Chair: Ms. Van Bommel.

Mrs. Van Bommel: Just to take that a little bit further, you were talking earlier about palliative care. In an earlier presentation, we heard from a group who were concerned about the erosion of palliative care at their local hospital. Where do you see the future of palliative care? Is it something that would be provided through home care? Should it be provided through the hospital? Or should it be something, as you're mentioning now, that moves back and forth? Where do you see palliative care going?

Ms. VanderBent: I was a palliative care social worker for three years at St. Joe's in Hamilton, and I think there's a need for many different doors to support people who are dying of cancer or any other disease. There is a need for a hospice, there's a need for home

care, there's a need for acute care and there's a need for long-term care. People die in many different places, and families and people have many different needs. I personally think the legislation in this system will provide a better opportunity for people to die with different types of options that will better support families and better support people.

The Chair: Mr. Jackson.

Mr. Cameron Jackson: Just on that point, however, there will be a distinction between the three palliative care options, two of which are not covered under the Canada Health Act. So yes, we may get increased patient choice, but there may be fees attached to it, which can occur outside of a hospital setting.

I want you to put your hat on with the Ontario Home Care Association. My question to you, Sue: Have you had any indication from the current government about how much of the community support envelope will be transferred to the LHINs and how much, if any, may be retained? I remember that, when I was the minister, staff recommended, "We should really be getting out of this business, Minister." It was just politically too untenable, so I said, "No, we're going to continue to do Meals on Wheels. We're going to do a whole series of supports." But you have municipalities getting community envelopes now for public health and regional health units, and that envelope has expanded. Have you had any discussions with the government to look at the community support envelope to say, "These are a couple of things that we're going to mandate to the LHINs," and therefore Meals on Wheels—I just pull that one out of thin air—will now be decided by the LHIN, or it'll be outside? Have you had discussions at all, in any kind of detail, so that we have a clue as to how this integrated—because that's your whole point: You're looking at the whole patient's needs, whether it's nursing, physiotherapy and so on.

Ms. VanderBent: I'm sorry, I haven't had those conversations, so I don't know the answer.

The Chair: Thank you for the answer. That's what he was looking for. Thank you for your presentation.

LONDON HEALTH SCIENCES CENTRE ST. JOSEPH'S HEALTH CARE, LONDON

The Chair: Next there will be two together, the 3:45 and the 4 o'clock. London Health Sciences Centre and St. Joseph's Health Care, London, wish to do half an hour together. Are they both present?

Interjection.

The Chair: They are outside? Can they please come in quickly? They're exchanging some ideas outside.

We are asking for the London Health Sciences Centre and St. Joseph's Health Care, London. Mr. Ramal, are both groups represented here?

Interjection.

The Chair: Okay. Thank you.

You can have a seat. We are going to have both presentations as a group. You have up to 30 minutes, half an hour. Whatever time is left will be available for questions and comments from the membership.

Mr. Peter Johnson: Thank you. I'm Peter Johnson. I'm a board member at LHSC. With me is Graham Porter, who is the chair of St. Joseph's hospital, and Diane Beattie, who is chief information officer and integrated vice-president of health information management and strategic alliances at both LHSC and St. Joseph's. What we're going to do in the form of our presentation is, first, address some issues within the bill; second, some specific issues with respect to LHSC; and then Graham Porter is going to address certain issues with St. Joe's as a faith-based hospital.

One of the unique things, I think, in the province is that in London, the two hospitals here and the surrounding community have been very, very active integrating the services with the region for a number of years. I think it would be worthwhile to apprise you of that and the things we've done, which really feed into the concept of the LHINs.

One of the distinguishing features of and the challenge for the LHINs will be to distinguish between the role of an academic centre and the community hospitals. It's been a continuing challenge for the academic hospitals to receive the appropriate funding for the additional level of activity they have as academic health sciences centres. As we know, there is going to be an increased desire on behalf of the government and the public for educating more health care practitioners, doctors etc., and that is the role of the academic health sciences centre. That is an issue that needs recognition within the LHINs: that there is a difference between the needs of an academic health centre and a community-based hospital.

The second issue is with respect to integration. As I said, Diane is going to speak to you at greater length about integration and its benefits. We clearly believe that, in order to provide the best health care for the citizens of southwestern Ontario, it has to be an integrated service model between the academic health sciences centres, the regional hospitals, the community access centres. We certainly support the concept of an integrated delivery system and have done a lot to do that.

Specific concerns with respect to Bill 36 include the fact that integration decisions do not require consultation with the hospitals. At present, there's a lack of criteria or guiding principles for integration decisions, and there's a lack of due process or mechanism for hospitals to appeal integration orders. Those are some specific concerns that we have with the legislation.

With respect to funding, that has continued to be the bane of our hospital's existence for many years. I've had a long relationship with the hospital, being chair of the Children's Health Foundation back in the 1980s, being on the Victoria board around 1990, doing the legal work on the mergers of the hospitals in London and the mergers of the research institutes, and just recently having rejoined the board, so I've seen it from inside and

out. The funding issues are a continual problem. We have had monitors, observers, outside consultants come in and review our operations inside out. All of them go away and say that it's a well-run facility, and still we don't have money to operate—

Interjection.

Mr. Johnson: Yes, and those cuts are being announced today.

That is a major issue, because as we transcend from the current situation to the LHINs, there are legacy issues we are faced with, enormous financial issues. I don't know how that transition will be made and whether they will get lost in the shuffle, but that is an issue.

At present, 60% of the patients at LHSC reside in London-Middlesex, 31% are from communities within southwestern Ontario throughout the LHIN, and 9% are from across the province and the country.

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Specifically with respect to Bill 36, our concerns in that regard are a lack of clarity as to how LHINs will make funding decisions in a geographic area or across areas representing the national scope that we have; secondly, the fact that our budget planning process has been so challenging, and the interminable delay in getting any resolution from the ministry for that.

With respect to the governance, one of the things that has made London so strong—and I can say it as a new board member tooting my horn, because I wasn't a board member when this was done. But having seen the work done by the boards in London over the last 10 years—I'll give you a small story. Back in 1990, when I was on the Victoria board, I suggested that the hospitals work together to do the best for our community. I was viewed as a heretic at that point in time because there was a Vince Lombardi attitude that each institution should be fighting for the dollars and fighting for the patients and not co-operating with the others in the city. London has changed dramatically over that period of time. We had Victoria Hospital and LHSC merge; we had the research institutes merge. We have integrated vice-presidents. We now have an integrated CEO. We've done a tremendous amount, and that has been due to the wisdom and leadership at the CEO level and at the board level.

I think the challenge for the government will be to ensure that they populate the LHIN boards with the same degree of talent that exists at the hospital boards, because they have a very, very challenging job and it's a very complex role. We would like to hope that the LHIN boards would be populated with people with expertise, community interest and an ability to do a very, very demanding job.

A point on my briefing notes is, "Establish criteria for when LHIN boards may meet in camera." Perhaps that will be dealt with in Bill 123, so we'll see what happens there.

In summary, just to end my remarks, LHSC supports the aims and principles of Bill 36. We're optimistic about it and we are prepared to take a leadership role, working with the South West LHIN, the other hospitals and health

care providers to improve the delivery of health care in this region. We believe it has to be done on an integrated model and support that. But we do join our peer hospitals in Ontario in advocating changes to the legislation that offer hospitals an explicit role in the consultation process for integration orders, greater clarity around funding issues, especially for academic hospitals, and a commitment to skill-based LHIN boards with local representation.

Mr. Graham Porter: My points, not surprisingly, will echo to a great extent what Peter has already said, particularly, unfortunately, around funding. However, we do want to thank you for the opportunity to present to this committee, because we at St. Joe's and also at LHSC view Bill 36—as we know this government does as well—as a pivotal piece of the legislation to transform our health care system.

Particularly with respect to this bill, I want to concentrate today on some of the themes that Peter has spoken about, as I said, as well as stressing St. Joe's faith-based mission, which is obviously of a great deal of importance to our board. But I also wanted to speak briefly about voluntary governance and the teaching and research components of both of our hospitals, which are critical to advancing health care in the province, and funding, of course, to support the continuum of care in our community.

The first thing I did want to touch on was the voluntary governance. We view it as critical—and we join the Ontario Hospital Association in supporting this position—that local representation is an important function for the LHIN boards, so that the LHIN board members understand the needs of the region and that we get the appropriate knowledge and skill set on the boards. First of all, we want to congratulate the people who have been appointed. Our board views the appointees as good choices, who have the appropriate knowledge and skill set. Our board looks forward to working with them in the southwest LHIN. As well, our hospital sees great opportunities to work across LHINs since, for both LHSC and St. Joe's, a number our patients, as Peter alluded to, are drawn outside our LHIN. We have a larger catchment area than just the physical constraints that were placed on us.

The next important point for St. Joe's is the faith-based mission. Ontario's health care system was founded, and continues to be stewarded, with substantial leadership and support of faith-based organizations. As a hospital in the Catholic tradition, St. Joe's has always tried to respond to the diverse needs of our communities while upholding accountabilities to our sponsors and to the government. We particularly have distinct guidelines which we uphold, in keeping with the Catholic health ethics guide of Canada, which corresponds to the objects of our owners, the St. Joseph's Health Care Society, and our bylaws and our values, listed in our strategic plan, of respect, excellence and compassion. This is fairly difficult in an era of integration and shared services, but we're proud of the collaborative models of leadership

and care delivery we've established with our partners while maintaining and strengthening our distinct mission. We believe that our entire community becomes stronger, and our Catholic mission becomes more valued, through shared understanding with our partners.

The next point I wanted to touch on was system integration. As Peter discussed, a major success story, in our view, in London and in the region has been continued sharing of services, sharing of CEOs, sharing of vice-presidents and resources. I think it's fair to say that London has been on the cutting edge of a lot of the significant sharing of resources and integration. And it's gone beyond London: We work with all the other six hospitals in the Thames Valley Hospital Planning Partnership. That deals with health care delivery, technology, patient records and supply chain initiatives. It extends not just to hospitals but to other service providers and care partners throughout the region, and not just the LHIN but southwestern Ontario. We've demonstrated that a variety of models, including joint ventures, shared services agreements, integrated functions and leadership structures can successfully and voluntarily be applied. The thing that I think St. Joe's is proudest of is that we've done a lot of these things on our own initiative.

As Peter said, the LHSC and St. Joe's boards work remarkably well together, in concert, with a view to the best interests of the community that we serve, and we're committed to continuing this approach. The one thing we would like to point out is that we're a bit concerned that Bill 36 doesn't establish enough of a framework for consultation about the integration decisions. We think guiding principles and establishing pre-set criteria for integration are vital. These are things that could be considered going forward. Alterations along these lines would be positive additions to the legislation.

I also wanted to touch on the mandate of academic hospitals. This is particularly important for London since some 3,700 medical and allied health students are taught in London's two academic teaching hospitals. Obviously, we're proud of our long history of teaching and research, and we want to make sure that this continues to be an important driving force in London and the region.

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I want to underscore the need to recognize the unique roles of Ontario's handful of teaching hospitals. While the government has rightly increased the number of university enrolments, our concern is that there has to be corresponding support for academic hospitals to reinforce the increasing number of health care professionals. In particular, St. Joe's capacity to offer rising student numbers the space and supports for learning is at a bit of a critical point and might even threaten the viability of some of our accredited programs.

Finally, I just want to touch on the funding issue. As always, the London hospitals are concerned about money. In London, there have been seven financial reviews in the past eight years, including a comprehensive review conducted in 2003, which was done in partnership with the Ministry of Health and Long-Term Care. These

reviews have basically failed to resolve the necessary funding levels identified for both hospitals. Obviously, we continue to work with the ministry on an ongoing basis to ensure full funding and to meet what we will consider our obligations under the HAPS for this fiscal year and next, and obviously, we have no issue with the concept of signing hospital accountability agreements. But we need to make sure we have dealt with the unresolved funding commitments; otherwise, we might have to deal with substantive reductions in patient care volumes or access to care, which obviously none of us wants.

We are concerned that the existing processes may become even more ineffective and burdensome if funding decisions are not clearly delegated to the LHINs or if somehow the accountability is not clearly passed from the ministry to the LHIN. There has to be clarity about how the LHIN boards will assume regional funding decision responsibility.

In summary, we want to continue to be an active leader and partner in transforming health care in London and to improve health care for all Ontarians. I think we've demonstrated our capacity and desire to continue to change and integrate, but we need to ensure that there's representative knowledge and skill-based LHIN boards. We want to ensure that there is good consultation and principles and criteria for integration, and we want to ensure that academic hospitals are given unique recognition. Finally, we want to make sure there is a framework on criteria for funding decisions.

Ms. Diane Beattie: This afternoon, I'd like to just give you a little bit of history on the integration model we've been using in London and how that has worked. As you look at the title "LHIN," I think the key and operative word for us is really "integration" and starting people to think about systems and how systems work.

If you go back 10 years, we had five independent organizations managing hospitals in the city. Today we have two hospitals on 10 sites. There's a resolve amongst the hospitals and the hospital boards to embrace what we're doing as a community resource and look at it as one community working together. Why the change from what Peter said was the Vince Lombardi approach of the previous generation? As you look at what we're trying to do and how we're working, there is a real need to understand that our human resource shortages are going to drastically change how we work together and why we need to work together.

The average age of a nurse in our community is 48. In London, we grew up with Freedom 55, and on the ONA side, there is 30 and out. So if you look at the number of nurses who will leave the profession over the next period of time, the expectation is that for every five who leave, there is only one in school coming behind. The *Globe and Mail* had an article about 18 months ago that actually said that for every eight and a half who leave across the country, there's only one coming in from school behind that group of nurses.

You don't have to look at just nurses. You can look at lab techs, you can look at radiologists, you can look at

every group of professionals in health care. So if we don't start to think about how to integrate and how to do things differently, we are not going to be successful and we will not have the health care system we need moving forward. As we've gone through this process as well, I think we've found that there have been significant efficiencies and better ways, and we've learned to do better things and to work together differently.

We started out in 1995 with the merger of three hospital campuses, which were then Victoria Hospital and University Hospital, and then we went into the HSRC directions in 1997. Through that time frame, the two London hospitals have been guided by 13 principles, and those 13 guiding principles are used today. We've followed them and watched what they're doing. The most critical of those guiding principles can be paraphrased: "Follow the patient's journey." If you follow how the patient flows through the system, then looking at integration and how to adjust your services and work forward is much easier.

Both Graham and Peter mentioned the integrated leadership model that has been put in place. I think, as you look at that, it's really important that you may have different missions but very much a common vision of where you're going and common values of how that needs to work. What we have, actually, is cross-appointment on our boards of directors, so the vice-chair of the LHSC board sits on the St. Joe's board and vice versa. I think it is really effective and has made a significant difference.

The key thing we're learning about integration, though, is what we call the C3 umbrella: Connect the continuum of care. In that, we've really invested in information technology to support the larger geographic region. Right now, we're working on all of Thames Valley, where we have everyone on the same digital imaging or PACS system. We've put everyone on the same hospital information system to create an electronic patient record. We've gone to what we call video care, which is telemedicine, so video conferencing from location to location, and we're actually sharing a lab system as well, which will dovetail into the EPR. You have to have a framework for people to share and a way for people to share. What we've found is that building that technology really makes a difference.

In the handout you'll see several places where, across southwestern Ontario, we have learned to share and collaborate in a number of things we've done. You'll see the referral patterns and the referral centres across our area.

I think the couple of things we would like to share, particularly with this committee and the LHIN boards, are the lessons we've learned about integration. First of all, it's tough to let go. Independence is cherished. We have to improve the way we make decisions collectively and bring more of a systems perspective—systems thinking is very difficult to get started; develop ways of working together that allow us to focus on the people, or patients, we collectively serve; demonstrate to the public,

our stakeholders, that we are working together to coordinate the delivery of care; apply best practices across that continuum of care; and the final lesson is, relentless effort to find the best ways to make collective decisions takes time and an awful lot of energy, and we really need to make sure we're focused in that perspective.

Our five critical success factors are: building trust and credibility of the players, so it's a people thing and a relationship thing first; perseverance—this is not something for the faint of heart; the old adage “communicate, communicate and then communicate again” is absolutely essential because, in a void of communication, people always understand and take the worst, never the best; you have to creatively develop your partnerships and then really make progress toward system planning and systems thinking. As we go forward, if we're going to be successful, I think the operative word in all of this is “integration.”

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The Chair: Thank you. We are just at the end, but I'll allow one minute each since it was a long presentation. Mr. Ramal, please.

Mr. Ramal: I have no questions. First, I want to thank you for coming this afternoon to do a presentation. I had the chance, over the last two and a half years, to meet with you on a regular basis and see your job. No doubt, to my mind and to many people in London, you are the leader of integration. You did your best to integrate all the hospitals in London and work together—not just in London but all around the Thames Valley area. Hopefully, you'll continue working with the LHIN in the future and try to integrate and consolidate service between yourselves, in Thames Valley and London, and in other communities and health providers in the LHIN boundary.

I also want to tell Graham about his concern. If you go back to the bill, to speak to your issue, your concern, I think clause 26(2)(f), if you go to it, will answer your questions.

The Chair: Mr. Arnott, up to a minute.

Mr. Arnott: You've given us a lot of information. I don't have any specific questions but I'm certainly looking forward to hearing from more hospitals as the hearings continue across the province. Your advice is very thoughtful and well presented.

The Chair: Thank you. Madame Martel.

Ms. Martel: Two of the three of you focused on funding as a major issue. I assume we'll see in the papers today what the result is of the deficit-cutting exercise that's going on. The reality is, though, that even if how money gets transferred down to the LHINs is sorted out or clarified in some way, if essentially the same amount of money is transferred down, your funding problem is not going to be resolved. It's only going to be resolved at the expense of other players in the system who would lose money in order for you to gain money to put you in a better position. The reality is, the funding issue is under the control of the government, not the LHINs. So if this

is not resolved already, and this legislation is before us, where do you see yourselves in the next two or three years as the transformation takes place, with essentially the same pot of money being downloaded?

The Chair: It's your choice; only one, please.

Ms. Martel: It's not a trick question.

Ms. Beattie: I think it's very, very important over the next short period of time that the funding issues that have been identified across the London hospitals, in particular, and the number of reviews we've gone through get resolved prior to the LHIN taking responsibility for the funding piece. If it doesn't, it's just going to cause a lot of heartache and discomfort for a group that needs to figure out how to work together. They will be diverted in their attention to looking at dollars and cents versus figuring out how to improve the care that we deliver.

The Chair: Thank you very much for your presentation.

CHED ZIVIC

The Chair: We'll move to the next presentation, which is from Ched Zivic. Mr. Zivic, you have 15 minutes total for your presentation and potential questions and/or comments. You can start at any time.

Mr. Ched Zivic: Thank you very much. I'd just like to make some comments and express some concerns.

Bill 36 represents a fundamental shift in how our health care system will function in Ontario. I have very serious concerns with respect to local autonomy, privatization and workers' rights. While it's widely acknowledged that financial and fiscal anxieties will always persist, we must, as a society, do the most civilized thing and put the welfare of the sick and the people who work on behalf of the sick in front of all other considerations. If Bill 36 is designed to use economic planning to serve the moral purpose of improving our health care system, why is an act of Parliament sabotaging this responsibility? This legislation raises some serious concerns with respect to where the fundamental sovereignty lies in our democratic society. Thankfully, today's forum will promote frank and open discussion. These proceedings will truly ring hollow if this legislation passes without serious consideration being given to the valued scrutiny of concerned health care workers, consumers and their unions.

Bill 36 exiles civic-minded, elected volunteers in favour of a paid bureaucracy of detached appointees who will be motivated by nothing more than a fiscal agenda. This will spawn the privatization of health care services. Moreover, the bargaining rights and collective agreements which took years to forge will be threatened, as well as those who contribute to the welfare of our young and our aged.

With the privatization model, for-profit providers fall beyond the scope of the Public Hospitals Act and are not accountable to the health care consumer because private business practices would restrict public access, and audit quality of service as predicated on cost savings, not

quality of care. The experience of P3 hospitals in the UK confirms that substantial reductions in service often occur in the P3 environment.

We have been excluded from providing input into what constitutes the parameters surrounding these accountability agreements, which are essentially fiscal targets set by the honourable minister. In turn, his authority is given to the LHINs, and they can create partnerships with other persons or entities, transferring, merging, dissolving and so on. When the 14 LHINs are up and running, hospitals will be forced to adopt fiscal targets and dictates set out by the network. Again let me stress that it is unclear what formula or model is used to establish this target, and there is no transparency, oversight or accountability.

Because I live in a small community, I fear that the larger urban centres will have a big advantage, because the larger centres represent a greater population and have entrenchment and long standing within the health care system. I suspect that the small institutions simply cannot compete or will not be allowed to compete. Regional inequalities will become a greater systemic problem because, when cost-cutting is the primary motivator, the most vulnerable will be affected. Rural Ontarians have a lot to be concerned about with this legislation. We always seem to be the recipients of made-in-Toronto solutions, and there exists a very real disconnect between urban and rural Ontario.

I've been a rural paramedic for 26 years and have seen first-hand how the value of numbers has driven policy with respect to service delivery. It is my understanding that ambulance services have been excluded from this bill, and I received an e-mail from the director of emergency services assuring me that the land ambulance will remain a municipal responsibility. But for how long?

In closing, I respectfully urge you to remind the government that it has the privilege and a responsibility to protect our health care system. If it chooses to go down this path, we will all become casualties of a distant, uncaring bureaucracy driven by a rationalized sense of immunity in pursuit of a balanced budget. The chasm will become an abyss if the architects of this legislation choose to ignore the concerns of the speakers who have stood before you today.

Thank you very much for letting me speak.

The Chair: Thank you, sir. We have up to two minutes for each group for comments or questions. Mr. Arnott, maybe you want to start.

Mr. Arnott: Thank you very much for your presentation.

Mr. Zivic: Thank very much you for listening.

Mr. Arnott: I have a lot of concerns about Bill 36 from the perspective of the opposition and from what I'm hearing. But I also agree that, generally speaking, the government needs to look within its means. If there's a health care budget, we need to stretch those available resources as far as possible so as to benefit patients. If we can find efficiencies and savings in the health care budget, that in theory should be driven into better front-

line services. I don't think you'd agree with any of that, would you, in terms of a general assumption?

Mr. Zivic: The notion of living within your means definitely falls within the scope of prudence and sensibility. I am not for one moment suggesting that we just recklessly go out and borrow billions and billions of dollars to sustain a system that is completely unsustainable.

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My basic problem with this legislation is that the democratic process has been somewhat usurped and that all members within the House have got to have some input into this process. More importantly, I think it is crucial that the confidence in our democratic system and our elected representatives remains sacrosanct. We have had scandals at the federal level. We have had scandals at the NHS in Britain, where this template was taken from. In 2000, Minister Clement went over, studied this model, brought it back, put a made-in-Ontario stamp on it, and now here we have to live with it.

That being said, I think it's incumbent upon the legislative process to acknowledge the needs and requirements to sustain and maintain a sensible level of health care, but not at the expense of the people who work within the system; the people who, every day, put their lives on the line—I can only speak of myself and my own profession—to deliver a system of health care. When you start opening the door to privatization, to the bidding process, there's automatically an entrenched mentality of these private providers that there has to be a 15% to 20% profit margin. But at what expense?

The Chair: Thank you. Madam Martel.

Ms. Martel: Thank you very much for making the presentation today. The opportunity for privatization in the bill exists in a number of ways: number one, the very real potential, to my mind, that cutthroat bidding or competitive bidding is going to be used as the mechanism for LHINs to purchase and acquire services; secondly, section 33, which allows the minister to decide which non-clinical services in a hospital are going to be contracted out, because "contracted out" means privatization; and the third area, where the minister can essentially shut down not-for-profit entities and transfer those to other areas, which could well be for-profit entities. So there's discrimination there, but a real potential for further privatization.

My concern around all of this is that if you have a limited pot of health care dollars, to my mind, it should be used on patient care, not on profits of big corporations or small. I don't know if you want to respond to that.

Mr. Zivic: Well, I can respond to that, because one of my biggest concerns—I sat on the hospital foundation in Hagersville, which is where I used to work before we were downloaded by the ministry to the municipality. We worked extremely hard to try and mobilize our community to support our hospital. We raised money for vital equipment. In fact, it seems that the hospital has come to rely on those funds to operate at a proficient level.

One of my concerns is, if this legislation goes through and we become the servants of this over 500-member

bureaucracy, which I think will be detached and not really serve the needs of the community to the same extent, what is that going to do to fundraising? What is it going to do to foundations that work within hospitals which are going to be seeing their services cut, where they're going to be seeing decisions made outside of their previous jurisdictions? I think that's very problematic. I think the perception will be that they have absolutely no control or no input, and no say, into how their hospital will serve them.

As I alluded to in my presentation, I think it's important to acknowledge the fact that smaller service providers, smaller hospitals, run the risk of being victims of this legislation, because when you try and centralize a big system like health care, they're going to look at cost-efficiencies. Part of that will be to streamline services, and privatization. Privatization is already here. We have Aramark. We have Sodexo. We have companies that do provide services to institutions. That's the loss of some very important jobs to the union workers. I think that will be reflected in the quality of care and the quality of service.

The Chair: Thank you very much. Ms. Wynne.

Ms. Wynne: Thank you. I just wanted to make a couple of comments, and then Ms. Van Bommel has a question. First of all, thank you for coming. I just want to say that Minister Smitherman has talked to a lot of people about this legislation, but Tony Clement is not one of them. I'm quite sure that Mr. Tory and Mr. Clement would not be in favour of this legislation because, in fact, it doesn't extend competitive bidding. Section 33, which Ms. Martel referred to, has its own clause embedded in it that would repeal that section once the processes that it's intended to complete are completed. I think those folks would not be happy with this legislation, because it actually does preserve the publicly funded system and that's its intention.

On the rural-urban issue, I really believe that this legislation is even more important for rural coordination. As an urban member and an urban resident, I don't think I worry about provision of service and coordination as much as people in rural areas, so I'm going to ask Ms. Van Bommel to comment on that and ask you a question.

Mrs. Van Bommel: Thank you very much. I want to just carry that further, because as a rural member, and having been involved in health care in my community in the past, I certainly know some of the difficulties that we experience in trying to coordinate the care.

We talked earlier and we've had different opinions expressed about the formation of these boards. Under the current legislation the membership of the boards is appointed, but we've had other people talk about an election. Now, if you look at the system, at the LHINs, how do you think rural communities would fare if we were to have elections of board members?

Mr. Zivic: I can only speak to my own experience. My wife sat on the board at the hospital and she was elected. I think it's important that we observe around this table that we live in a pluralistic, democratic society. I

think all groups within that society have to be equally served. One of my concerns with respect to this legislation is that the rurals could be balkanized, could be absorbed, especially those rurals that are very close to larger centres. I can speak to emergency rooms. A number of years ago there was a proposal put forward that our emergency room should close in my small community. The community mobilized; it stayed open. I think what's going to happen here is, if a community is threatened, or their hospital is threatened—because you have to realize, in the small communities, it's not just a hospital; it's a hub within that community. It provides jobs, it provides a very essential service. A lot of times, communities put their own hard-earned blood, sweat and tears and equity into that hospital decades ago to build it, to make sure they did have access to health care.

This legislation, I think, jeopardizes that. I really think that we can be lost in the shuffle. I think this bureaucracy can be very detached. I think you have influences that come to bear behind the scenes, and we all know that the way politics works is that the biggest stakeholder will get the loudest voice. I don't see any guarantee in this legislation that the rural hospitals will be given a fair and level playing field.

Mrs. Van Bommel: But if you look at the situation now where LHINs such as the one we're in right here and you have a centre like London, how do you think the rural communities around London would fare in an elected process?

The Chair: A quick answer, please.

Mr. Zivic: You know what? I'm really not exactly certain what you're asking. We're talking about process here, and as laudable a concept as that is to discuss, I think it's very important that we never lose sight of what this legislation is all about. I think that the way the hospitals were set up, the boards were set up, these were very dedicated individuals who really wanted to see the hospitals improve, move forward, provide a high level of service. Prior to this legislation, I think that that was happening. I'm not sure that would be maintained under this legislation.

Thank you very much.

The Chair: Thank you very much. We just went over the time; otherwise, I would have allowed—but that's fine.

Mr. Zivic: I appreciate that, thank you very much.

The Chair: We appreciated your comments and your presentation.

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WENDY MANZIE

JADE CAMPBELL

The Chair: The next one is from Wendy Manzie and Jade Campbell. Thank you for coming, both of you. I understand you're making a presentation together. There is a total of 15 minutes.

Ms. Wendy Manzie: I'll be brief. I'm Wendy Manzie. I live in Sarnia. I'm not as familiar with the

forum as many of the other speakers today, so I'm just going to go ahead and read my statement.

According to the ministry's release on the proposed Bill 36 draft, "The purpose of this act is to provide for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care and effective and efficient management of the health system at the local level by local health integration networks."

The geographic areas of the proposed network are prescribed through the local health integration network maps. Erie-St. Clair, or LHIN 1, residents are here in London today because the ministry is not holding these public meetings in each of the new geographic regions. This may have been an opportune time to introduce the public to the new boundaries.

Coming from Lambton county, I believe the ministry has to recognize that the separation of London Health Sciences from this part of southwestern Ontario is not a user-friendly move. While the bill allows for "no restriction on patient mobility" and is directing that each LHIN therefore "not enter into any agreement or other arrangement that restricts or prevents an individual from receiving services based on the geographic area in which the individual resides," the bill does not provide assurance for funding for the mobility; that is, the transportation of patients and/or their families or support systems.

To name a few of the objects of this bill, and I've taken chronological liberty with these:

(a) to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for the community input and consultation;

(b) to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services they receive;

(c) to undertake and participate in joint strategies with other local health integration networks to improve access to health services and to enhance the continuity of health care across local health systems and the province;

(d) to enter into agreements to establish performance standards and to ensure the achievement of performance standards by health service providers that receive funding from the network.

Does this mean that the intention of the bill is to take direction and input from local taxpayers, or just lip service of an intended, yet-to-be-established process that no ordinary citizen would be able to successfully navigate? Are we to assume that current hospital follow-up in long-term and diagnostic services will be available within reach of our current local public transit systems? Will the members of each community be properly informed, let alone have some true input on the health care services provided within their communities? Will there be an additional tax, not unlike the recently implemented provincial health care premium, just to maintain present levels of service, or will residents have to adjust or lower their expectations?

Ontarians, as both health care workers and potential health care consumers, should not be subject to a disconnected health care system. The proposed bill calls for us all to rely on the kindness of strangers to provide our most intimate, essential health care services. This is potentially going to leave many of our most vulnerable people unable to access or feel comfortable with an unfamiliar, potentially transient health care system. For workers, this legislation will potentially discourage current experienced providers from continuing in their field of expertise if it means they will have to disrupt their lifestyle and livelihood by commuting long distances and no longer having a sense of being valued by and for their community.

That sense of belonging will be nonexistent for new workers, thus drastically changing the climate of caregiving. Future health care workers are less likely to commit to an education that will require more time and money than their desired field of expertise will justify, considering the competitive bidding process and its inevitable lack of job security, low wages and undetermined term contracts.

Does the current provincial Liberal government have a template of the proposed performance standards agreement included in Bill 36? Are the citizens of Ontario to accept that our health care services are for sale to the lowest bidder? Can we afford to give such an all-encompassing piece of legislation our sleepy seal of approval? Considering that each individual LHIN may determine what services it deems financially feasible in any given geographic area, this inevitably will lead to a two-tier system. The for-profit clinics have made their intention clear—to take advantage of the opportunity to fulfill the demand for convenient one-stop health care services—while the proposed LHIN system will have patients traveling across the countryside to access health care services.

The current provincial government should take notice, as the former federal Liberal government has recently experienced, that Canadians are not prepared to accept a plutocratic system for our tax dollars. Will this proposed legislation just create another layer of bureaucracy, and at what cost to our health care system, which is already bleeding out from excess administration costs?

The proposed bill includes 14 government-appointed executive boards to consist of not more than nine members, including a director or chairperson. The office space has already been rented, and there is an allowance for an undetermined number of office staff, whose salaries have not yet been disclosed. Executive board members will have a term of three years initially. The board of directors and committee member selection process will be controlled by the minister, with the minister's discretion as to their renewal.

The potential for conflict of interest on these boards is undeniable, yet the bill allows that they will develop their own policies. The bill calls for all meetings of the board of directors of each health integration network and its committees to be open to the public, except if the

Lieutenant Governor in Council prescribes otherwise. What specific criteria will be used for this discretion?

While the objectives of this bill may be well intentioned, in its current state there are too many opportunities for system failure. The reorganization of health care in this province is in order, but Bill 36, as proposed, is not the catalyst for positive reform. Without proper inclusion of the unions representing health care workers to create a positive realignment of health care services for the people of Ontario, there can be no improvement to the health of Ontarians. The unions have a long, successful history of advocating not only on behalf of the caregivers, but for the vulnerable in our communities as well.

The Chair: Thank you very much for your presentation. There is about a minute for each group, and we'll start with Mr. Fonseca.

Mr. Fonseca: Thank you very much for your presentation. Just before you presented, we heard from a number of groups, two of them being St. Joseph's hospital and the Ontario Home Care Association, both local entities. One is a large hospital; the other is really care in the community and in the home. They addressed the LHIN legislation and, yes, they made some recommendations, but they said it is so needed to provide that continuum of care, especially at those transitioning points. Today that's not working very well in many instances in the province when someone is post-op or whatever it may be and getting care in the community.

Do you believe that we can better our system by the LHIN legislation, that we can bring our standards higher, so we can see what's happening in Ottawa or what's happening in North Bay or what's happening in Windsor and be able to take the best, like what's happening here in London, and transplant that around the province so we can raise our level of care and provide the best care for 12 million Ontarians?

Ms. Manzie: I would like to be optimistic about the intention of the LHINs, as drafted, but I don't see that patient care, bedside—the consumer of health care—is going to be served by this legislation. I understand that there is duplication of administrative services, but I also see, as I pointed out, that the private sector has spotted—and there are the clinics that are proposed for Ontario where it is one stop. People don't want to have to go to emerg and then come back to another ambulatory care half an hour away. It would be nice if every community could have the services available.

In the rural and smaller communities across the province—Sarnia isn't really rural, but it is considered one of the smaller areas—there is a really hard time enticing general practitioners, family doctors, to those areas. If there is not the support in those communities for those family doctors to give to their patients, we will not have family doctors and everybody will be travelling.

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The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. Would you ideally want this committee to recommend that Bill 36 be withdrawn?

Ms. Manzie: Ideally? As it is presently? Yes, absolutely.

The Chair: Thank you. Madam Martel.

Ms. Martel: Thank you very much for the presentation. I wanted to focus on the assurance that people will be able to access health care services outside their LHIN. We had a presentation this morning from a group from Petrolia, who, at the end of their presentation, quite clearly told this committee that—and I don't know the circumstances; I'm assuming someone's going to find out about this—they could not get health care service in London, even though the minister had said that you could go outside your LHIN boundary to get service. I remain very concerned that while the minister may say this, at a certain point in time, if funding isn't shuffled around so that you get service outside of your LHIN boundary and that service is paid for, sooner or later you will only be able to access service in your LHIN area. Given some of the geography here, and the fact that the referral patterns don't make sense in so many of these LHINs, that's going to mean an incredible hardship on many people who may have to travel very long distances in order to get care, or be getting care from specialists that they previously could see before the LHINs and now cannot because they're outside of that LHIN boundary.

Ms. Manzie: Yes, absolutely. I happen to be a paramedic, and with the downloading of the ambulance five years ago, it was supposed to be seamless and boundary-less and all of the rest of it, as far as municipalities go. The municipalities do bill each other when there is overlap, and I can see that the tax base for the LHINs will be done the same way. But at the same time, we don't have any assurance within the LHIN legislation to state that there will be the temporary cost-share, if you will. I'm not familiar with how exactly it would be administered as far as billing the other LHIN and whether or not they would have access to the ministry to get extra funding for those services.

I'd like to point out as well that an hour from Lambton county is one of the best services for health care in the world. When we look at different types of illnesses, as far as head and chest and different illnesses and injuries and neonates, they cannot travel by helicopter, they cannot travel by air. Going to Windsor, there is no straight road from Petrolia, Sarnia, anywhere. It's very rural, and it's dangerous with the trucks. We've all heard about all the accidents on the 401. Putting an ambulance, by land, on that road any more than we have to, because of just the shuffling for fiscal reasons, is insane.

The Chair: Thank you.

Ms. Campbell wanted to speak to us too. Why don't you give us your presentation, please.

Ms. Jade Campbell: Good afternoon, Mr. Chair, committee members and honoured guests. My name is Jade Campbell, and I am a health care provider and health care user. I live in Cambridge, Ontario, where I was born, raised and work. My parents were immigrants from China and built a family business in Cambridge.

As part of the sandwich generation, I've witnessed the evolution of health care first-hand. My parents and

godparents had to shoulder the cost of their health care in the 1950s. I remember my godfather as a single income earner paying his bills to the hospital every month. He did his doctor's landscaping on weekends to pay down his bill. My grandfather contracted tuberculosis and succumbed to the disease after a lengthy stay at a sanatorium. The bills for his care were borne by my family. My mother and father were the sandwich generation before there was a term for it.

I speak today to support a strong and accessible health care system that was a godsend for my parents and grandparents and to ensure that it remain a viable service for myself, children and their future generations.

I live in a small community, Cambridge, which has a growing population of 120,000 people. Presently, Cambridge Memorial Hospital provides its citizens with services that are essential in raising a family and taking care of its elderly.

The LHINs legislation has the ability to change the landscape of my community health care. I know that in my community there is mistrust of this government's ability to listen to our health care needs. In the fall, there was a great hue and cry from the Cambridge citizenry when our capital project was denied. Kitchener and Waterloo received approvals for their capital projects. From the Hansard of November 24, 2005, MPP Elizabeth Witmer responded to the Honourable George Smitherman: "For example, let's take Cambridge hospital. Maybe the reason the money is not flowing to Cambridge is because there is a secret plan in the minister's office to do away with Cambridge hospital and shift the services to one of the other Kitchener or Hamilton offices."

Despite petitions and pressure from our community groups, the government placed our project on hold. But just before Christmas, the Cambridge capital project was approved. Cambridge people were elated and duly noted that it was impeccably timed with a hotly contested federal election in our riding. What is the saying? "You can fool some of the people some of the time."

The proposed LHINs are not local. They are not based on communities and they do not represent the communities' interests. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

The autonomy of the LHINs from the government will be negligible. The provincial government appoints the LHIN boards, and LHINs will be required to sign memorandums of settlement and performance agreements with the government. So LHIN boards will be responsible to the provincial government rather than the local communities. It's a Senate-type thing, with some accountability. Without a code of ethics and conflict-of-interest blueprint, the potential for a train wreck remains to be seen.

This is in contrast with a long history of health care and social service organizations in Ontario, which as a rule are not appointed by the provincial government. For example, the provincial government does not appoint hospital boards, and they have effectively and doggedly

fought for better funding for their communities with great success.

The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely. Small communities are particularly threatened. Too often rural communities have seen reductions in service shift with the centralization of services to the larger regional centres. Likely, the provincial government will respond to complaints by stating, "It wasn't our decision; it was a decision of the LHIN." Yet the LHIN will largely be unaccountable to local communities.

A key goal of this reform is to reduce costs by integrating services. But this also raises questions about cutting services. At first, the government talked only of integrating support services. But cutting back support services is (1) dangerous—a prime example is the SARS infection crisis and threats of pandemics; and (2) inefficient—as an example, the recent elimination of PSWs at Cambridge Memorial resulted in their patient assists being downloaded to our RNs and RPNs.

Major steps are now being taken to integrate support services on a regional level. New organizations are being established to take over and centralize support services formerly provided by hospitals, homes and other non-profits, with many of the services then contracted out to for-profit corporations. This is a major change in the structure of health care and social services that may have far-ranging consequences for workers and local communities.

The hospitals have balked at an exclusive focus on support services. Simply integrating support services cannot satisfy the cost savings demanded by the government; the savings would also require clinical cuts. I know that in my hospital there has been consideration for eliminating our pediatric and obstetric programs, its cancer clinic and laboratory services.

Certain populations in my community are going to be vulnerable and easily marginalized by decreasing the accessibility of services. These communities include: gays/lesbians, racial minorities, isolated seniors, the homeless, underemployed and underhoused, people with cultural or linguistic barriers, single parents, and those who are in a lower socio-economic group.

In Ontario, where distances are particularly large, this could add a lot of travel. But even where distances are measured in several miles rather than hundreds, specialization creates special problems for patients. Instead of being able to deal with all of their problems at one centre, their health care services are spread out over many health care providers, creating a real problem for those with multiple health issues, and especially for the elderly and the poor.

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The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation within the LHINs. With cost-cutting a key goal for the provincial government, the question will arise: What services will be provided in each area of the LHINs?

It is ironic that individuals in middle and upper socio-economic groups design programs that are intended to provide assistance to the lower socio-economic groups with little or no input from their target population. It is common knowledge that those individuals from lower socio-economic groups have a lower health status and a higher morbidity and mortality rate from most diseases.

We need (1) strong representation of all stakeholders from communities on the boards and committees to give voice to all citizens; (2) equitable access to services for smaller communities; (3) ensure that funding does not shift away from smaller communities; (4) transparency in board appointments so that the positions are based on skills and ability and not on a partisan political designation; and (5) focus on community needs as opposed to cutting services.

We need to address (1) inadequate acute care programs; (2) easy access to services for patients who have ongoing chronic care illnesses which reduce their ability to live in their own communities; and (3) providing the proper funding to promote health and prevent illness.

In conclusion, the Canadian health care system is founded on principles of universality and accessibility. The state of our health care is significantly compromised if services in our community are integrated or cut. I would like to refer the committee to the five principles of the Canada Health Act, which is committed to ensuring that all levels of government uphold (1) comprehensive coverage of all medically required services; (2) universal coverage for all Canadians regardless of income; (3) accessibility to all residents uninhibited by user fees; (4) portability of coverage from province to province; and (5) public administration of health care on a non-profit basis.

I thank you kindly for providing me with the opportunity to make this presentation.

The Chair: Thank you very much. There's no more time for any questions. We thank you for both presentations.

STUART JACKSON

The Chair: We have the next person waiting on the telephone, I believe. The next will be a conference call. Can we start the process, please? Hello?

Mr. Stuart Jackson: Hello.

The Chair: This is Chairman Mario Racco and we are prepared to listen to your presentation, please. You have 15 minutes total. If you don't use the full amount, we'll be happy to ask questions and/or make some comments. Please proceed.

Mr. Stuart Jackson: Okay. I read the bill over the Internet. What I found is that (a) people who are on welfare, social assistance and other benefits from government will fall through the cracks if the bill goes through. The bill should not go through as a result of what I can see there; (b) I could visit rural areas in the summer—I know a town, Restoule, Ontario. There's not one public hospital anywhere in that area. The nearest hospital is in

North Bay. I found that one out from a hunting trip. A hospital should be built in that area of Ontario; definitely, yes.

But when I look at other things within the whole bill, the answer to this question is, yes, we do need to modernize and bring our health care up to standard and up to par because the system has degraded somewhat since Harris took power. When Harris took power, it had degraded. Now, Harris is no longer in power. We need to come back up again, yes, but to come up at the cost of the federal and provincial governments, not at an actual cost to the rich people. I say, rich people can afford to pay to go to a hospital or to health care, and the poor, the needy people who are going to fall between the cracks, they're the ones who are entitled to the same benefits as the wealthy rich people are entitled to.

That sort of, to my sense, concludes the presentation, to keep it short and to move on to the next person.

The Chair: Thank you, Mr. Jackson. If you can wait there for a moment. Madame Martel, would you like to start, please? We have maybe a few minutes each, plus.

Ms. Martel: Thank you, Mr. Jackson, for joining us. In the first part of your presentation you said you had taken a look at the bill on the Internet and that you were concerned that people on social assistance were going to fall through the cracks. I think that's what you said. I'm not trying to put words in your mouth. Can you just expand on that thought for me, please?

Mr. Stuart Jackson: I can see in that bill where somebody goes to hospital, they present the OHIP card, and the hospital says, "I'm sorry, we can't accept that till we get verification." They will leave that person out on a stretcher, and that person's critical. The person who had the money gets treated quicker. On the OHIP card itself it should have ODSP so when it goes through the system, then the person gets in right away and is not stuck in a hallway to die.

Ms. Martel: Your reference is to ODSP, that there should be something on the health card that identifies someone who is on ODSP. Is that what you're saying?

Mr. Stuart Jackson: Yes, and also something on the health card that identifies somebody as being on welfare, like something identifying a person on welfare or a person who's on Indian Affairs benefits and other benefits.

Ms. Martel: In that way, you feel that it would make it really clear to people at the hospital that this is an individual who is entitled to receive health care services at that hospital in Ontario?

Mr. Stuart Jackson: That is correct.

Ms. Martel: Okay. Thank you.

The Chair: Ms. Wynne, please.

Ms. Wynne: Thanks, Mr. Jackson, for taking the time to talk to us. I just wanted to talk to you a minute about the issue of having to travel long distances. This has come up a number of times today, and I just want to clarify what we're trying to do.

By having these local health integration networks, we're trying to make it so that the procedures and the services that people need close to home and that happen

frequently are available to people. For the once-in-a-lifetime things, where you need a hip replacement or a knee replacement, there may be some travel involved. Because what we know is that if you go to a place where those things are done a lot, you're going to get better service. But for the things that you need on a regular basis, that's the kind of thing we're trying to keep close to home. That's why we're putting more money into home care and more money into procedures like dialysis that people need on a regular basis. We're trying to arrange it so that people don't have to travel for those things and also provide the best service.

Do you want to comment on that?

Mr. Stuart Jackson: Yes, I do want to comment. What I'm concerned about is—in Hamilton we've got some of the finest hospitals around, from McMaster Hospital down to Hamilton General Hospital and St. Joe's, but they do that service on a regular basis, on a day-to-day basis. But if you travel in areas like far northern Ontario—I visited the town of Restoule, Ontario, and there was not a hospital for miles in that area. So that is an area to build and construct a hospital, because in the summertime the town itself had employment from tourism, but in the wintertime they had nothing to keep the town going. So by building a hospital, not only would it generate construction jobs, but it would also generate employment because people have to be employed to work in hospitals. That means development in the town and business is brought into the town that basically doesn't do much in the wintertime.

The Chair: Thank you, Mr. Jackson. That terminates this presentation.

We will be able to move to the next presentation from the Ontario Health Coalition, the Canadian Association of Retired Persons, CARP, London chapter. Is anyone here for that deputation?

If they're not here, I'll see if someone from the Sarnia Health Coalition is here. Is there anyone from the Sarnia Health Coalition?

The next one would be the Ontario Medical Association, London chapter. Is anyone here from that?

Those are the last three deputations that we have on the agenda. We'll wait a few minutes because we are ahead at this time. What we can do is take a five-minute break, and we'll come back when there are people here.

The committee recessed from 1650 to 1705.

SARNIA HEALTH COALITION

The Chair: I believe Arlene Patterson of the Sarnia Health Coalition is present. If she is, would she please come forward? We have 15 minutes for your presentation and potential questions and comments. You can start any time you're ready, please. Thank you for coming.

Ms. Arlene Patterson: I've submitted my presentation in writing to you already. At this late time of the day, I'm sure that you have heard, so far, many points with regard to this proposed legislation. I certainly don't want to read verbatim the written submission. However, I

would like to point out that we are the Sarnia Health Coalition and we are a part of the Ontario Health Coalition, which—

The Chair: As you said, we have your presentation, so anything that you may want to stress, the membership may wish to ask you a question on.

Interjection.

The Chair: We just received it. Am I right? Yes. So we haven't necessarily read it yet. Is there anything specific you want to underline that you put in writing for us?

Ms. Patterson: Well, I haven't been here all day, so I'm not really sure what other panels or other people have presented. Certainly we are 50 strong local health coalitions across the province and we're associated with the Ontario Health Coalition, who have over 400 affiliate organizations across the province. So we speak with some credibility in that we are not a small group, by any means.

I'd like to do two things in the 15 minutes: one, highlight some of the points that we're concerned about with regard to this legislation, but also talk about my personal experience as a patient within the system. I've been in the system as a patient for 14 years now and I've certainly seen many changing elements of our health care system. Some of them are of grave concern to me, as well as to other people I know who have also been in the system.

I'll start out by saying that this legislation, at its very core, is basically another health restructuring act. We've seen the restructuring that was done by the Conservatives. Most of that hit between 1995 and 1997. During its tenure, the Conservatives' Ontario Hospital Services Restructuring Commission issued final directions to 22 communities, affecting 110 hospitals. These directions amalgamated 45 hospitals into 13, and closed 29 hospital sites. The worst years were from 1995 to 1997 and immediately after, when the Conservative government withdrew approximately \$900 million without warning from hospitals, cutting 9,000 critical, acute and chronic care hospital beds and laying off approximately 26,000 health professionals.

We find, quite similarly, that this legislation, if brought into being, certainly has some sweeping new powers to it, as did Bill 8 with the Ministry of Health.

Is the mike cutting in and out, because it certainly seems like I am.

The Chair: No, that's fine.

Interjection.

The Chair: We can hear properly.

Ms. Patterson: We see that this bill gives the Minister of Health central control, and also gives him major new powers in order to restructure and contract out. The main new powers include:

- the ability to order transfers of services, personnel, property and funding, with limited appeals and compensation;

- the ability to order the closure, merging and transfer of all operations of any non-profit, but not for-profit, service providers.

—We also find it disconcerting that a new structure for the health system ruled by the health minister's strategic plan is set unilaterally and enforced ultimately by court order.

—the ability to override protections and provisions in legislation covering civil servants, corporations, expropriation and the Statutes Act among others.

1710

This bill affects 10 other pieces of legislation, and one of our concerns is that this has not been reviewed very effectively in terms of the impact on that other legislation.

This bill empowers the ministry, directly and through the LHINs, to execute a new restructuring of the health care system. The legislation confers powers that expressly override previous legislation that set out processes for the disbursement of charitable or non-profit property, the guidelines for the civil service, compensation for expropriation of property, or processes for the enactment of statutes.

Centralization and the lack of democracy: The only thing I'd like to speak to there, other than what has been mentioned, is that there are no normal democratic protections against in camera or secret meetings. The public is shut out, basically. Yes, there is a provision here for notifying the public for meetings, but the wording is so vague, which makes us wonder whether they're actually encouraging the public to become involved or not. Why does this government envision a system in which democratic rights regarding the health system are less than those in any other sector?

Although this legislation does not directly state that they don't encourage privatization, just the mere fact that that statement is alluded to in this legislation would bring us to have some concerns in several ways. I will just list them as they are written:

(1) The LHINs may move funding and services from non-profits to for-profit services corporations.

(2) Cabinet may order the wholesale privatization or contracting out of all support services in hospitals.

(3) There is no definition in any Ontario legislation of what constitutes "non-clinical" services. Under this legislation, cabinet is given the power to define these services as broadly or as narrowly as they wish.

(4) The minister may close or amalgamate non-profits, but not for-profits. It is not difficult to foresee a shrinking set of non-profit providers while the for-profits continue and gain new market opportunities as the system is restructured.

The competitive bidding model, which we've seen in CCACs across this province over the past 13 or 14 years, has pitted non-profit and for-profit organizations and companies against each other. It has created a very unstable market. The costs here are huge in the duplication of administration costs.

But I would like to focus on the costs to the patient. That's where I leave my written submission. I would just like to say that there are those of us who are "sick," and then there are those of us who are sick. I speak in the

latter category. I depend on this health care system, and I have for the past 14 years. Most of my treatment is conducted within the hospital. I know that while that's still possible, I'm covered under the Canada Health Act insofar as I'm not going to be expected to pay out of pocket for the treatment I receive. When this LHINs legislation is passed—and I hope it isn't, in the way it is written—what would it take for that whole question of outpatient services being put in the community and taking away our safeguard, and then being charged out of pocket for services that we have received in the past? That's a real concern, not only for myself but for many other people who, for example, receive IV therapy within the hospital. I have seen patients be approached by head nurses, unit coordinators, saying, "Your IV therapy has been discontinued. It has been delisted from the Ministry of Health. Therefore, either you pay for this drug or hope your insurance will cover the costs of the drug." What this does to patients is unbelievable, because we're not prepared for that. We didn't plan our retirements around making a specific budget line for medical treatment. We haven't had 30 years to work towards our retirement fund that would include those medical expenses.

Certainly we've seen the recent movement of the Copeman company, which wants to create private clinics with sort of social club fees for memberships. This is a very elitist move, and it's people like me, who are in need of treatment—I wouldn't be here if it weren't for my treatment. So what do we say to the people in the hospital already? We know that if this LHINs legislation is passed as it's written, the powers the Minister of Health has can, with the brush of a pen, eliminate, amalgamate or transfer any service within a hospital to the community. What that says to me is that the protection I have had while I've been in hospital—well, you shake your head. I've known people who would ask their physicians to be admitted into hospital so their drugs would be covered. As soon as you are categorized as an outpatient, there are certain costs associated with that. If you or a family member hasn't been in that situation—these things are done very insidiously, and they're done on a one-to-one; it's not a public piece of information that is out there.

The Chair: Thank you, madam, for your presentation. We've used the 15 minutes on the presentation. We also have in writing what you wanted to tell us. We thank you for coming and speaking to us on this very important topic.

Ms. Patterson: You're welcome.

STANLEY KORCHUK

The Chair: Could the Ontario Health Coalition and the Canadian Association of Retired Persons please come forward? Sir, you're next. You can start any time. There is 15 minutes total time that you can use to speak to us or for us to ask you some questions.

Mr. Stanley Korchuk: I'll probably take up all the time.

I'm a little presumptuous, perhaps, in saying that I represent these organizations, because I think I tend to be a bit off the wall on some of these things. However, I will report back on the results of this and I will present my paper. I haven't had time to present my paper to these organizations. I wanted to be a little more careful about what I say here as far as whom I represent.

Anyway, thank you for allowing me to appear before you. I'm 76 years old, and I guess the health care system becomes more important the older you get. What I learn, I intend to transmit, as I said. I hope too that what you will hear from me will be worthy of your attention and consideration.

The Chair: It is.

Mr. Korchuk: Thank you. Anyway, I've read through Bill 36, and there are a few ideas in there. I'd just like to summarize what I perceive about this, and I'll be very brief.

1720

It certainly exceeds the health restructuring commission of 1996, which I remember we had to cope with when I was on the hospital board up in Bracebridge. It's much more comprehensive. It covers hospitals, psychiatric facilities—a lot more things than the other one did—but it seems to exclude some other things. I kind of like the idea of integration, but not everything seems to be integrated.

New powers will be vested in these LHINS, as I see it, and the minister will be given profound power. I happen to have worked with the government, the same business you—not in health, but in education—so I know a little bit of its internal workings. I have a great respect—I didn't until I went to work, believe it or not. I developed a lot of respect for our government, but not until I got inside and got to work with ministers.

That LHIN service accountability agreements with health providers must comply with the minister's strategic plan, and compliance will be backed by court orders sounds a little authoritarian. Services may be contracted out, merged, transferred, etc—this is all old stuff for you; you've heard it 100 times. Property also can be transferred. Any current local control will be overridden. I liked the autonomy I used to have up in Bracebridge. I was in charge of the recruitment of physicians, and we took great pride in our hospital. I wonder if some of that is going to be subtracted. Of course, that's not all.

First, I wish to compliment the Minister of Health and Long-Term Care, his ministry and the government for conceiving and initiating legislation to create an integrated approach to the delivery of health care. It is a concept I identified and favoured when I served as a trustee on the board of the South Muskoka Memorial Hospital. But I also found, and I'm sure you will too, that it was not a very popular concept in the medical community. I had some awful battles: nurse practitioners versus doctors and stuff like that. All change is hard on the people targeted by change, especially when clumsily managed.

If this is not justified, please send one of these back to me and say, "You're wrong, Stan," or the paper is wrong,

because there was a report on January 9 that 300 jobs were lost to health office closings and the workers were terminated by video. As a supervisory officer in education for many years, if I did that, I'd be fired. It's a very personal and very painful thing to go through for the recipient of the bad news.

The intent, according to the article, which quotes David Jensen, who I guess is a deputy minister of health, is to restructure health care in order to improve the system by closing 14 of the 42 community access centres. I think that was insensitive. One can expect only a big corporation to treat its employees in such a depersonalized way. I just want to throw that in, because I think a lot of other people felt that way in this city.

I do believe in an integrated, multidisciplinary organizational structure for the delivery of health care, but not one that is incomplete. I don't know whether you can overcome that. I know how tough that would be, and I can probably surmise why you didn't do it. Why were all the others left out?

I have a graduate degree in educational planning. I learned that there are principles of good planning that apply to all organizations. For example, included should be a clear expression of the goals and objectives and a precise identification of the advantages of the new over the old way of delivering health care. I know that behind the scenes this was all deliberated.

Nevertheless, the LHIN is a fascinating concept for me from a planner's point of view—I'm putting that hat on right now. It reminds me of the principle of subsidiarity. Do you remember? That was used in Europe when they developed and formed the EU. The principle of subsidiarity asserts that decisions—listen to this carefully—should always be taken at the lowest possible level, that the effectiveness of both the government ministry and an institution for which it is responsible is diminished by undue centralization, that consolidation can be a weapon of tyranny and that adherence to the principle of subsidiarity protects democracy.

I think Bill 36 touches on that violation of subsidiarity. But then the centralizing impulse is afflicting all modern democracies, everywhere you go, all over the world. There are exceptions starting up in some parts of the world, but I won't go into those; this is not the place to say that. I think the LHINs are a perfect example of that centralizing trend.

I would recommend to you a review of all levels of decisions and responsibility. Then I urge that all decisions and responsibilities be reassigned to levels in the government and in local and regional agencies consistent with the principle of subsidiarity. I know I won't get that, but I'm just throwing that idea out.

Public input, of course, is important. I said something earlier about objectives, that there weren't—there are objectives in here. As a planner, I can read through this and I know, when you write this, that there are objectives embedded that are quite clear. I'm not going to list them, because you know them all. One objective is to revamp the delivery of care, but the LHIN will not provide it; it

would just revamp it, as I understand it. Competitive bidding is important. For-profit health care corporations will be sort of integrated into that system—a potential dilution of the principles of the Canada Health Act, perhaps. At least it's not mentioned very much. Again, correct me if I'm wrong—not now, but maybe if I get one of these back. If you really disagree with me, I'd like to hear it, because I think my associations would like to hear about it, so bear with me a little longer.

The consolidation of hospitals into specialties troubles me a little bit. It's obvious to you, so I won't go into it. That those servers who bid less or more efficiently will be rewarded by more grants troubles me a little bit.

Public access to LHINS: The whole operation seems to be constricted, or at least constrained. Each LHIN will be accountable to the government and not to the public. It's really a top-down type of thing. I hate to say this, but maybe it's necessary at times.

These performance indicators really bug me. I came across them as a trustee. I'll tell you why they bug me. I've studied them all over the world, especially in England lately. They've got them in England, where quality is becoming hostage to the emerging private health care market and cost overruns. When you set up performance indicators, they become powerful tools for government control, but once you focus on a measure—and I have a physics background—the uncertainty principle moves in. I don't know if any of you have studied this, but the uncertainty principle is just a measure that doesn't mean anything. It's hard to swallow.

I just wanted to share that with you. I'm going to finish up. If you could do something for me: Make a few notes on this thing and tell me where I'm full of BS and where I'm not, and I'll pass the information on to the RTO and CARP members. Thank you very much.

The Chair: Thank you for your presentation. You're right on the 15 minutes, and I'm sure any of us may wish to take you up on that request. You may hear from someone.

Mr. Korchuk: I really would appreciate that, because it shouldn't stop with me.

The Chair: Thank you again for your presentation.

The last presentation for the evening is from the Ontario Medical Association, London chapter. Are they present? Those of you from London in particular, do you recognize anybody? No.

Having said that, they are scheduled for 5:45, and it's 5:30. To be fair, we should hang around another 15 minutes. Maybe we can have a walk. If they do attend, we'll start over again. Otherwise, we'll leave.

The committee recessed from 1730 to 1735.

ONTARIO MEDICAL ASSOCIATION, LONDON CHAPTER

The Chair: Can we resume again? It's the last presentation, and I understand that Dr. David Paterson is present. Dr. Paterson, if you can take a seat at the front, you'll have about 15 minutes to make your presentation.

In any time left, we may be able to ask a question or make some comments. Start any time you're ready.

Dr. David Paterson: I can start now?

The Chair: Yes.

Dr. Paterson: Mr. Chairman and committee members, good afternoon. My name is David J. Paterson. I'm the past president of the Essex County Medical Society, and I've worked as a family doctor and an emergency doctor in Windsor, Ontario, for the last 30 years.

One of the reasons that I'm here is because I'm a front-line physician, but also I was a member of the Essex County District Health Council for about seven years and was directly involved with the restructuring process of health care in the Windsor area. This was the predecessor to the LHINs, and I want to make sure that you don't make the same mistake that some of the district health councils made.

Thank you for allowing me the opportunity to speak to you today about Bill 36. I warn you that I may stray from my notes because I just drove here from Windsor and I did some thinking along the 401, and you'll see me wander around my page with the thoughts that I had. My presentation will be brief; I suspect it has been a long day for everyone on this committee. I'll answer questions at the end if you so wish.

There are many positive aspects—am I coming and going on this?

The Chair: If you could move just a little farther from the microphone.

Dr. Paterson: I'm sorry. Is this better?

The Chair: Yes.

Dr. Paterson: All right. There are many positive aspects of this legislation, but there are also areas where improvements can be made. These improvements—actually, I just want to talk about one improvement, which I will speak about to you today, that will result in better and more efficient health care for all people in Ontario.

We're all aware that doctor shortages and wait times are chronic problems in the Ontario health care system, especially in family practice. Any government initiatives that may ease these problems and improve health care are most welcome.

Ontario is the last province or territory to regionalize. Local health integration networks will be an interesting challenge. Different areas of Ontario have vastly different needs and concerns when it comes to health care, so the LHIN concept may work very well.

The doctors of Ontario want to help our patients receive the best health care they can get. Doctors are intimately involved with every aspect of health care, from birth to death. We are the gatekeepers of the system. We have direct involvement not only with the patients, but with hospitals, nurses, home care, palliative care, all types of therapies—physical, mental, pharmaceutical—and every allied health professional, as well as local, provincial and federal politicians and the media.

Recently, the Ministry of Health and the Ontario Medical Association reached an agreement about physician remuneration. The majority of doctors applaud this

agreement. It would seem opportune to continue this spirit—this is where I go around my page—of support and co-operation. With the current shortage of physicians—this is expected to get worse through retirement and loss of physicians to other provinces and to the US—it would seem a very bad idea to end this period of public spirit and co-operation.

It is my understanding that doctors have no formal role in the LHIN process. We have an indirect opportunity to provide input to the LHINs via a health providers committee, one that I understand is comprised of all types of health care providers. This is insufficient and, in my opinion, quite dangerous because physicians are so intimately involved with all aspects of health care. Without direct input from local physician groups, LHINs seem doomed to failure. The result will be a profound waste of money and no improvement in care. A good analogy, to me: Starting a LHIN without direct physician input would be like amputating one of your legs before starting a marathon. It's that strong of an analogy and it's really true.

There is a role for all health care providers in this process. It's not up to me to decide where the other professionals will find their place. I can only speak to the role of the physicians and how crucial their input will be in the success of local health integration networks.

Recently in Windsor, we had a meeting of what they call OMA, district 1, which is physician representatives from Essex, Kent and Lambton counties, and our guest speakers were the CEO and the president of the LHIN representing our area. They spoke about their concept of LHINs and met with all the physicians and answered questions. They seemed very supportive of direct MD input and felt it would help both ways—LHINs to physicians and physicians back to LHINs.

If you get too far down the road without doing it right the first time, it will be very difficult to restructure and maintain the confidence of an already skeptical public who only want better care. And an election is not very far away. It is my suggestion, and a suggestion from the OMA's board of directors, that each LHIN have a standing committee of local physicians, both urban and rural physicians, that can provide the necessary input to allow LHINs to effect constructive, progressive and positive change. Without this input, it is impossible for LHINs to do their job effectively.

It was my experience on numerous occasions with the district health council in Windsor that physician input was absolutely critical. Without this type of information, major errors would have been made that not only would have been costly but detrimental to the health restructuring process. I can give you examples of those. I'm trying to make clear that the health care problems unique to Windsor, Essex, Kent and Lambton counties are well known to the physicians who practise there on the front lines every day. This type of input is absolutely critical for the LHINs to work effectively.

Please change the LHIN structure to have a physician subcommittee that reports directory to the LHIN execu-

tive and make this a mandatory requirement. Without this change, the LHINs cannot function to their full potential. Doctors want this system to work. Many people think that doctors are trying to take control. This is absolutely untrue. We want to ensure that our patients have the best possible care. We want to see the waiting lists shrink and the pool of physicians grow. We want to be able to work more closely with other health care professionals for the betterment of our patients' lifestyles and well-being. We want to help you make Ontario the best place to give and receive care, and I think this is possible. Thank you for hearing me today.

The Chair: Thank you. We have about a minute plus for each. Can I start with Mr. Jackson, please?

Interjection.

The Chair: I'm sorry, I just looked at the name tag, not even the face. Mr. Jackson was here; he left. Mr. Arnott.

Mr. Arnott: It's the first time I've been confused with Cam.

Interjection.

The Chair: I like him; I think he's a nice guy.

Mr. Arnott: Thank you for your presentation. It was excellent. You indicated that the district health council that you were involved with had made a number of errors without the input of physicians, or would have made serious errors without the input of physicians. Can you give us a couple of concrete examples that come to mind?

Dr. Paterson: The restructuring involved going from four hospitals down to two hospitals. We were trying to rationalize where orthopaedics would go, where pediatrics would go etc. It's a very long process.

In combining the two hospitals and determining where the beds were going to go, the people on the district health council, without a physician, were unaware of the requirements of operating room time, of the way it worked in a hospital, and what would attract physicians to an area, what would keep them. From a surgical point of view, it's really OR time, and this is extremely difficult to obtain in the current system. The district health council was proceeding without this knowledge and making all kinds of grandiose plans that were not realistic. In that particular instance, I just simply pointed out that we cannot attract without having the necessary OR time.

We talked about changing pediatrics from one hospital to another. The problem with that was that neurosurgery was remaining at the hospital; pediatrics was leaving and going to a hospital that no neurosurgical backup. This is medical information input that they required before they finally made their last submission.

Mr. Arnott: When you pointed out those practical problems, you were able to—

Dr. Paterson: It wasn't from a selfish point of view. It was really to show what was happening.

Another example would be, there are fewer and fewer family physicians. From what I understand the LHINs do, care of people out in the community requires a CCAC etc., and this involves the care of a physician. If they

don't understand why family physicians are getting more and more scarce and work with the government of Ontario and the OMA to change that, no matter how many CCACs, social workers or whatever type of support work they want, it's not going to work. We're not trying to drive it. We're just trying to give them information so they can better arrive at a conclusion.

The Chair: Ms. Martel, please.

Ms. Martel: Thank you for driving up from Windsor today. I wanted to get back to your role at the district health council and then what you're proposing for the LHIN. Correct me if I'm wrong. You sat as a member on the district health council among a number of other consumers and health care professionals. Is that correct?

Dr. Paterson: Yes, I did.

Ms. Martel: So you weren't part of a specific physician subcommittee reporting to the district health council on proposals, ideas, changes etc.?

Dr. Paterson: No. I was on the executive.

Ms. Martel: You've already said to us that as a result of your role as a physician with, I would argue, a broadly based group of people, you were able to make changes, and important changes. Correct?

Dr. Paterson: I was able to give information so they would arrive at better—

Ms. Martel: Why wouldn't the same type of thing work on a LHIN? You were a physician sitting as a member of the district health council with other, I'm assuming, consumer members and members of other health care professions, and you were able to give your input that resulted in important changes. Why wouldn't the same thing work on a LHIN? If there were physicians sitting on LHINs with other health care providers, why wouldn't the LHIN recognize your input in the same way and make important changes?

Dr. Paterson: I was just handed a note, but I can't read it.

To be honest with you, I don't know. It seems like it's a point that doctors are not included on the LHINs, and I don't know why.

The Chair: Thanks very much. Ms. Wynne?

Ms. Wynne: Thank you very much for presenting to us. I wanted to ask you about the health professionals advisory committee. You're making a proposal that there be a separate committee of physicians, and we're suggesting that there be a combined committee. The question is, how workable do you think it would be—and I know you've said you can't speak for other health professionals—to have a separate advisory committee for every single health professional? Wouldn't it make more

sense to bring the health professionals together and have them work out what the common advice should be? I'm a doctor's daughter, so I know the primacy of doctors, but I think what we're trying to say is that all those health professionals have a role to play.

Dr. Paterson: I have no doubt that they have a role to play, but physicians have the biggest role to play. If the role of allied health professionals was looked at as a pie, a big chunk of the pie is physicians. Because we're so intimately involved with this on so many levels and we represent the patients directly, that's why I think you need direct physician input.

I really can't speak for other health professionals. Nurses would be a big role as well. But other health professionals would be way down the line—and this is my personal opinion, not from the Ontario Medical Association. But if you do not have direct input from the physician group—I understand that LHIN 1 goes from Windsor right up north to Owen Sound or something; I don't know. But that's a huge, diverse area. If you did consider physician input, I would think that the doctors would have to get very busy in making sure they had input. I have no idea what the medical needs are in Owen Sound, and they don't know what we need in Windsor or Leamington. It would be up to us to provide a committee that would give you direct input.

Ms. Wynne: I'm being cut off. I just wonder why doctors couldn't provide leadership on those committees and work with the other health professions, but we'll probably have to discuss that more.

The Chair: If you could quickly, if you have a quick answer.

Dr. Paterson: I'm sorry?

The Chair: If you have an answer, that will be fine.

Ms. Wynne: About providing leadership on those committees, not having a stand-alone committee.

Dr. Paterson: I think the role of the physician is so unique. It's not a blend of working with a dentist or a physiotherapist or a social worker. The medical community is unique and extremely important.

Ms. Wynne: Thank you.

The Chair: Thank you again for coming all the way from Windsor.

Thank you to all of you for participating here in London. We appreciate your comments. We are going to Ottawa tonight so tomorrow we can get some more input in that area and do a better job. Thank you again.

The committee adjourned at 1752.

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Legislative Assembly of Ontario

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Assemblée législative de l'Ontario

Deuxième session, 38^e législature

Official Report of Debates (Hansard)

Wednesday 1 February 2006

Journal des débats (Hansard)

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**Standing committee on
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Local Health System
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**Comité permanent de
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STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Wednesday 1 February 2006

Mercredi 1^{er} février 2006

*The committee met at 0902 in the Crowne Plaza
Ottawa Hotel, Ottawa.*

LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

DR. DENNIS PITT

The Chair (Mr. Mario G. Racco): Good morning. It's nice to be in Ottawa. We will start the meeting right away, with your permission. The first item on the agenda this morning is the Ontario Medical Association, Ottawa chapter, Mr. Dennis Pitt. If you would start, please, there's 15 minutes, total time. Whatever amount of time is left will be available for potential questions and/or comments from the membership. Please start any time you wish.

Dr. Dennis Pitt: Thank you very much, Mr. Chair. With me today is Dr. Steven Harrison, who's with the health policy department of the Ontario Medical Association.

I'm speaking to you from the perspective of a practising physician, as a surgeon who's been in practice in Ottawa for 25 years. I do sit on the board of the Ontario Medical Association and I'm a member of the board of the Ottawa Hospital, the Canadian Medical Association and the Canadian Association of General Surgeons, but my comments are my own as a practising surgeon and they're not necessarily a formal policy of any of the organizations that I'm associated with.

To begin with, I've looked with some admiration at how the LHINs have been brought out. I've had an opportunity to talk with my colleagues in some of the other provinces and I think the politicians and the civil servants who are behind this have learned from the other provinces. Specifically, practising physicians are much happier with this coming in at a measured pace, as an evolution rather than the revolution that took place in some of the other provinces. Hospital restructuring has already been done and the hospital boards have been left

in place. I think this is much better than, specifically, Alberta, where a lot of doctors were very upset and there was massive upheaval; and, of course, there have been no massive budget cuts with this.

I understand that these are much different than the health authorities in the other provinces, and that's what we have to compare them to. Hopefully, this will work much better in looking after accountability and planning than the health authorities have elsewhere.

In this particular LHIN, I would like to compliment Michel Lalonde, the chair of the board, and Robert Cushman, the CEO, who have been around talking to groups of physicians all over this LHIN, from Pembroke to Cornwall, with a variety of physician groups within Ottawa. We're very pleased that they've communicated with everybody. They're happy to listen to everybody, and I compliment them.

What we're looking for the LHINs to accomplish: Physicians like to look after their patients. We're interested in patient care. In especially the last 10 years, every physician and surgeon I know has been doing more and more paperwork at the expense of patient care. We're also very frustrated with the amount of bureaucracy we have to deal with. I don't mean the bureaucracy at the Ministry of Health; I mean the bureaucracy of managing our patients. We're spending far too much time on the phone, organizing tests, investigations, trying to get patients seen. This is extremely frustrating to physicians. It's driving some physicians to quit medicine and some to leave the country. I've sat in on some focus groups and that is the number one source of frustration for physicians. We're looking to LHINs to improve this. We're very hopeful that they'll be able to cut through this bureaucracy and excess paperwork.

I'll give you one example that's happened recently so you'll understand what I'm talking about. Pembroke is a city just a couple of hours' drive northwest of here. They had two general surgeons. I'm a general surgeon, so this is why I'm so familiar with this. One general surgeon left last fall in November and the remaining general surgeon broke his arm. So they had no one. They sent an urgent request down to the Ottawa Hospital for a surgeon to do locums there, if we could help them out any way.

One of my colleagues who has been a general surgeon in Ottawa for more than 25 years, who trained in Ottawa, a very competent general surgeon, said, "Well, yes, I'd be interested in finding some time to help them out." He notified the Pembroke hospital that he was willing to do

what he could. The reply was that he had to go through the application process as if he was a brand new surgeon coming from who knows where. He had to get his college documentation, all the paperwork, including three references, so he could help them out. I talked to him two weeks ago and, in fact, he did all that. He was interested to see how this process would turn out. As of two weeks ago, he had still not received notification that he could work in Pembroke at that hospital. This was in response to their emergency, their crisis in November. That's the kind of problem we would very much hope LHINs will address and relieve us of.

My only concern with the LHINs that I see is the way it refers to physician input and representation to the LHIN. There's a small section that refers to a health professionals advisory committee. I've read it and I reread it again this morning. It's very vague and unclear. It's not at all specific about how physicians should have input to LHINs. I'd like to emphasize that physicians need formal input, number one, so the LHINs can take advantage of our knowledge or expertise. We're the people who directly look after patients in hospitals. Patients have a nametag on their wrists with the patient's name and the physician's name on there. That's who the responsible person is. When they look for primary care, they go their family doctor. I'm not putting down the other professions. In no way are my comments derogatory to them, but I want to emphasize where the responsibility ultimately lies for people, especially when they're in hospital. So we think we have a lot to contribute as far as advice. In no way do we want to make final decisions, but we think our advice is valuable.

Secondly, we think LHINs will be far more successful if they get the buy-in and the support of all the practising physicians. I think the way to do that is to have a formal structure that can relate to LHINs and be part of the LHIN establishments in the respective areas.

We did have a meeting before Christmas—the Ontario Medical Association organized it—between practising physicians and the Ministry of Health. I thought it was a very good meeting; some very good suggestions came out of there. I think that should be looked at very carefully with the final form of the LHIN legislation.

Thank you for this opportunity to speak to you. I'd be happy to have any discussion.

0910

The Chair: Thank you. We have about a minute and a half available for each group. I will start with Jim Wilson.

Mr. Jim Wilson (Simcoe—Grey): Thank you, Doctor, for your presentation. I'm a former health minister, and I hear you about the bureaucracy. You were very kind about it, I think, in terms of the hoops you have to go through to get your job done. Don't think the minister doesn't go through the same type of hoops at Queen's Park.

Just in terms of the OMA and yourself putting forward the suggestion that you have more input in the decision-making process at the LHINs, exactly what are you

looking for—your own committee? I guess the way it is now you'll be one of 22 or 23 regulated health professions on that committee. Do you want to explain further what you mean?

Dr. Pitt: Certainly. These are not hard and fast things that we're demanding. Out of discussions with my colleagues here in Ottawa and at the OMA and out of the discussion in the meeting that I mentioned before Christmas, the principle we came up with was that an advisory committee should have representation from hospital-based physicians as well as community-based physicians, representation from specialist family doctors and also, specifically for this LHIN, representation from the city, like Ottawa, plus somebody from the smaller community.

We did say that we didn't think this committee should be too large, excessively large. Numbers were tossed around between five and 10; that sort of thing. Also, we considered whether these representatives on the committee should be elected or appointed. Most people thought, some combination; there are advantages both ways. That is the basic principle that we talked about among the physicians.

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning. The process you were referring to when you gave us the explanation of the situation in Pembroke: Is this the hospital process to provide privileges?

Dr. Pitt: That's not very clear to me as a practising surgeon here in Ottawa either. I don't know how that got derailed. I don't know the kind of bureaucracy involved. I know the message came out on the e-mail from the chair of our department looking for people to do locums there. This surgeon, a colleague of mine whom I talked to, was not clear why he had to do all this either. I did not pursue it. I didn't call the Pembroke hospital. I didn't look for details. I don't want to blame anybody; I don't think that's the point here. I brought this up because I think this is something LHINs can deal with.

I had an opportunity to go out to Alberta in 1999, and their regionalization was very rapid and upset everybody. They initially had excluded the physicians. In 1999, there was a big, huge project to re-involve physicians. They have credentialed physicians for the entire region. For instance, I have privileges at the Ottawa Hospital only; that's the only place I can work, whereas, in the regions in Alberta, for instance in Calgary, you have privileges in the entire region, so you could easily move from one hospital to the other for hospital-based docs. I would think the LHIN could facilitate something like that quite readily.

The Chair: Thank you. Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Thank you, Dr. Pitt, for being here. As you acknowledged, we've heard this a number of times from some of your colleagues in Toronto and in London. As you reference, subsection 16(2) is where the health professionals advisory committee is outlined.

Our concern is that we hear from all health professionals, that all health professionals have input. If we were to start down the road of having a separate com-

mittee for each health professional group, that will be unworkable.

You've made the remark today about having the different doctor specialties represented on this committee. If we were to accommodate that notion—not talking about majority or minority, but just recognizing that there are specialists, there are family practitioners, there are different doctors who need to be represented—on this multidisciplinary committee, would that go some way to resolving the issue for you?

Dr. Pitt: That's a very good question, and I've given that some thought. The first presentation I heard, from Michel Lalonde and Robert Cushman, said that there were over 200 different health care groups and agencies within this Champlain LHIN, which really made me blink. I'm a practising physician. I'm not all that attuned to all that. I thought, "Wow, have you ever got a big job to sort all that out."

You certainly don't want to exclude the other regulated health care professions. The details are going to have to be worked out so you have them as well. I'm really not qualified to comment on how to represent them the best. I hate to hedge on your question, but I really haven't figured that out. I think it's really difficult.

The worst thing that could happen is that it's another layer of bureaucracy and it's just another layer of administration. We really don't want to see that happen. It has to be streamlined some way.

Ms. Wynne: We need the best advice. That's what we need.

Dr. Pitt: Having one physician in a room with 20 other health care representatives for a meeting: We don't see that functioning very well. We all go to meetings where you sit forever, and we're very uncomfortable with that. I think that's the best I can say at this stage.

The Chair: Thank you, Dr. Pitt, for your presentation.

SUE MCSHEFFREY

The Chair: The second presentation is from Sue McSheffrey. Good morning. You can start any time you're ready, Ms. McSheffrey.

Ms. Sue McSheffrey: I'm the pink presentation, the pink lady.

The Chair: Yes, a nice colour.

Ms. McSheffrey: It won't get lost.

Good morning. Thank you so much, and welcome to Ottawa. My name is Sue McSheffrey. I'm a physiotherapist working for the community care access centre in Renfrew county. It's Ontario's largest county. It starts an hour west of here in Arnprior and ends, over two hours past there, near Mattawa.

Mr. Richard Patten (Ottawa Centre): Is that walking or running?

Ms. McSheffrey: By donkey.

Our community has serious concerns about the proposed legislation, especially the misnomer of "local." There is nothing local about a bureaucracy that extends from the edge of Montreal to just outside of North Bay.

LHINs are not local. They serve populations the size of whole provinces like Nova Scotia, Manitoba or Saskatchewan. Some are the geographic size of France or Germany. So I want to know, why is the government calling them local?

Within our own true local health care community, we're concerned that staff will have no protection from being moved around within the LHIN. A good example is my situation. I've been 15 years as a physiotherapist in home care. We go from nine physios, full staff, to two. If the Cornwall area, say, is short of physios, will I be driving three hours to cover that area? No one knows. We're told that those details aren't available.

I'm here to tell you that workers like me are sick and tired of being guinea pigs for change. The health system is not so broken that it requires this level of government intervention. All of the problems we do have come from things that the LHINs will not change, like not enough doctors in rural areas. The doctors, gatekeepers of the system now more than ever, are left out. Why? Why did you not take the chance to bring doctors into the core of our health system instead of leaving them on the fringes? Our area of Renfrew county would be much better served if you put physicians on salary and controlled where they can practise. This is a key component of the British system that the McGuinty government seems to love and is so set on copying, so why ignore it?

0920

Health science professionals are in short supply. The money being wasted to rearrange the bureaucracy could be used to provide bursaries to students in these fields. It doesn't matter how you reconfigure things; if there aren't enough radiation technologists, you can't do more treatments.

There are two areas that I consider myself an expert in. One is the disaster that has become the British National Health Service. It boggles my mind that anyone in government would use the NHS as a model for health care. Rationalization resulted in my mum being sent two and a half hours north of her home in Stafford for surgery because they were the cheapest centre to bid on that surgery. This resulted in no visitors and expensive transfer costs, as mum had to pay a driver to get her there.

Rationalization in Renfrew county could mean the end of our local hospitals, like the Deep River and District Hospital or the Arnprior and District Memorial Hospital. Patients from our area will have to travel farther. Winter travel from Killaloe to Ottawa is not always an option. We have no public transit.

How people access services and fairness across Ontario is as important as the services themselves. The range of health services offered in a community can determine more than just access to health. Health care providers are also key employers in many towns. It's often the only place to get a good job. The removal of key services from a community can lead to other economic losses. Businesses often consider local infrastructure when they decide to locate or relocate. The loss

of a hospital or the downgrading of a hospital to a clinic could hurt or discourage business.

My second area of expertise is in health planning. I was a founding member of the Renfrew County District Health Council and the last chair before the Harris government silenced us for good. These LHINs are being implemented with no local planning. As someone who worked hard to engage our county in meaningful planning, this terrifies me. There is no plan. The government wants to set up the LHINs first, then plan the system. It should be the other way around. Since everyone at the district health councils has been fired, there has been no health care planning in the province. They stopped the planning in January 2005; the planners have all been laid off. Where are you getting your information, or are you just winging it?

We see the LHINs as government-appointed executive boards with a mandate to continually merge and transfer services somewhere within the vast LHIN region. With the ministry, there was accountability through the local MPP in question period and ultimately through the polls on election day. This removes our power to do anything through the political arena in the short term. In the long term, we'll be sure to remember this in October 2007.

The LHIN board will have no power, as the government hired the CEOs, not the board. In other words, why appoint a board that cannot select its own CEO? The board will be puppets of the government, but without public accountability.

There were seven regional offices set up at the turn of the millennium to plan, manage, fund and monitor the system of health care programs. They're being replaced by 14 unaccountable LHINs that appear to have the same mandate. The LHIN CEO will be paid about twice as much as the regional directors, and, of course, there are twice as many LHINs as regional offices. Do you honestly believe that this is giving better value for the supposedly scarce health care dollars?

Lastly, this health system of ours has undergone so much political tinkering that the surprise should be that we're still functioning at all. Ontario's health system is not seriously broken and does not need such a massive and costly reorganization of the system. In fact, the risks outweigh any potential that I can see that would emerge from the restructuring.

There's more than enough money being spent on the health care portfolio, much of it on things other than health care. For example, in my sector, home care, the shift to privatization has been a consistent cost driver. Across Canada, the sector has undergone a massive shift from not-for-profit to for-profit delivery of care. Costs have increased by 21.3% a year from 1980 to 2001; this has not been matched by service increases. When Ontario enacted a one-year funding freeze in 2001, service to patients was cut by 30%. Our clients are getting less care for more money, and it's not being spent on salaries and wages.

The legislation sets out a process whereby the CCACs will amalgamate to fit the LHIN boundaries. There is no timetable set out for this to take place, meaning the

CCACs could be out of sync with the LHINs for a long time. Moving from 42 CCACs to 14 will create fresh chaos in the home care sector. Decision-making authority will be taken much farther from local communities. Health care providers will likely bid on contracts covering regions four times the size. This may particularly impact smaller providers, especially if regulations remain in place limiting the number of providers that can share a given contract.

And then, what about us? There are nine CCACs like ours with direct service providers on staff. We don't fit into a plan like this. When I met with Elinor Caplan, she argued with me that there were no direct service providers left in the CCAC system; ministry staff had told her. Maybe you can understand our levels of anxiety around this huge rearranging of health care when staff don't even know what the present system looks like.

This committee has the power to fix all of this. The LHIN concept is flawed and is being rammed in without adequate planning or consultation. For example, in human resources, my union, OPSEU, has not been consulted about the impact on its members; neither has any other health care union been involved. There is no HR strategy other than using the Conservatives' Bill 136. No legislation should go forward without a human resources plan. Without health care workers, you have no health care system.

This plan must be negotiated and include, at a minimum: layoff provisions, like layoff as a last resort; measures to avoid layoffs; voluntary exit opportunities; early retirement options; pension bridging and protection of pension funds; retraining options; and successor rights and protection of collective agreements.

I'm already involved in a class-action lawsuit against the crown after our pension plan was screwed up by the last provincial government. Why invite war when there is no need? All we want is peace and stability, so that we can focus on what we're trained to do for our patients.

Please resist the urge to dismantle and rebuild just for the sake of marking your territory, and go out and buy a Lego set instead. In the end, it'll cause less pain and frustration, and we'll still have a health system that's the envy of the world. Please put the brakes on this legislation until you've properly thought through the impact on health care workers, patients and their home communities.

Thank you.

The Chair: Thank you. There are 30 seconds each. Madame Martel, would you like to start?

Ms. Martel: Thank you very much for your presentation today. I'm glad you pointed out that the problems that we have come from things that the LHINs aren't going to fix at all, because the actual fact of the matter is that the system and the amount of money that goes in is determined by the government. Who gets access to services is a function of the policies and regulations of the government, and the LHINs have absolutely no power to change either of those two things.

I just wanted to focus on competitive bidding. You didn't touch on it directly, but I remember a previous

presentation from you a couple of years ago, I think at this same hotel. The government says that there's nothing in the legislation that says the LHINs are going to use competitive bidding to acquire services, but the legislation also doesn't specifically prohibit the use of competitive bidding. What has it been like in home care, and what do you think will happen if the LHINs use that for all of the services they are going to be acquiring?

Ms. McSheffrey: When I met Elinor Caplan, one of the things she said to us was that part of her mandate was to review competitive bidding, because it could be used as a model within the LHINs of procurement for services, which is the British system, which is why my mum ended up going where she did for her surgery.

In home care, it's been absolutely chaotic. Nobody has any stability with their job. Everybody is worried about two years down the road, three years down the road, when the contracts expire. It's meant that colleagues of mine were unable to get mortgages, because the job that they had was only good for the length of the contract. So even though health professionals are in short supply—they can walk into a job anywhere in Ontario—because they're short-term contracts, you can't get loans.

0930

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. Just a couple of comments. There is nothing, as you know, in this bill about competitive bidding. It's silent on that. I am sure you're aware that Leah Casselman has met with the minister on a number of occasions, so she has been in conversation. You said your union had not been consulted; in fact, there have been conversations.

I wanted to just go to the point about the lack of access to MPPs. I'm really confused about why that would be something you'd take from this bill. MPPs are going to be as accountable as they have ever been. You have access to your MPP before this bill is passed and if it's passed. So I think that misinformation is pretty problematic. People in Ontario will continue to have access to their MPPs if there are concerns about the health care system. I'd just like you to comment on that.

Ms. McSheffrey: The concern I have is, right now if the health policy comes down, questions can be asked in the House and it's a decision made by the Minister of Health.

Mr. Patten: They still can.

Ms. Wynne: They still can.

Ms. McSheffrey: Under the LHINs, the LHINs are going to be making decisions. It's one step removed. That's what I'm talking about. So the MPPs don't have the same control through the House.

Mr. Patten: They never had before.

Ms. McSheffrey: But you can raise questions from the floor.

Ms. Wynne: That's what happened—

The Chair: I believe that the lady made her position, and you also did what was proper.

I would ask Mr. Arnott—30 seconds, please.

Mr. Ted Arnott (Waterloo–Wellington): The government members are quite right that the opposition will continue to ask questions in the Legislature about health care, but I can tell you what the minister's response is going to be. The minister is going to say, "Oh, I had nothing to do with that decision. That was a decision that was made by the local health integration network. Go talk to them." So it's absolutely true that there's a political buffer that's being created by this bill, designed to protect the minister from difficult decisions, so as to remove accountability and blame to a local board. That's really what the government's agenda is all about with Bill 36.

The Chair: Thank you for your presentation.

HOPEWELL EATING DISORDERS SUPPORT CENTRE OF OTTAWA

The Chair: The next group will be the Hopewell Eating Disorders Support Centre of Ottawa.

Ms. Joanne Curran: Good morning. Thank you very much for inviting me here today. My name is Joanne Curran.

I've asked to speak with you because I think that I am able to give you multiple perspectives as to why it is so critical that this government recognize eating disorders as a special provincial program rather than have these disorders managed by the LHINs.

What makes me qualified to comment? For starters, I am the mother of a young woman who, at the age of 12, began a cycle of release, relapse and readmission; where anorexia crippled her once athletic body, crushed the joie de vivre that she had as a child and nearly claimed her life.

As president and co-founder of Hopewell, an eating disorder support centre in Ottawa, as well as a charity, I hear all too often from sufferers who, time and again, face barriers to treatment and from parents of children who they fear will lose their lives because of having to wait, sometimes for months, for assessments.

As a representative of Hopewell, I am also actively involved with a provincial network of peer support groups and, therefore, am very aware of what treatment is or is not available in places like Sault Ste. Marie, London, Burlington, Toronto and Ottawa.

Lastly, I am a nurse by profession who has spent the past 30 years in health promotion and disease prevention.

I know that some members of this committee are well informed about eating disorders and understand the serious nature of them. For those of you who are not as familiar about this serious public health problem, let me begin by saying that eating disorders are not about food, nor are they about vanity, nor are they about a 15-year-old who is looking for attention; rather, they're a means to control a life that otherwise feels out of control. They are a mental illness with serious physical consequences.

What brings one bright, ambitious youth to an eating disorder is often completely different for someone else. What is similar, however, are the devastating social

consequences of anorexia and bulimia. Not only do they derail someone's school, work and family life, they also seriously compromise peer relationships and lead to serious health problems that can be carried into adulthood.

Children as young as nine are now being admitted to hospitals with anorexia. These kids are younger, they're sicker, both medically and mentally, and harder to treat, leading to repeat hospitalizations for medical stabilization.

The unanticipated increase in the prevalence and severity of eating disorders has created an urgent demand for expert resources within each region of this province. By expert resources, I don't mean family physicians, who themselves have admitted to lacking the necessary expertise to treat the high and complex demands of a severe and chronic illness.

Regrettably, many regions across this province have neither intensive eating disorder services nor the experts needed to deliver them. In those regions where there are these services and these experts, nowhere is there the full spectrum of services for eating disorders that best practices have shown to be absolutely essential for successful treatment of these very chronic illnesses. Indeed, staff and services have had to be cut to balance hospital budgets; this in spite of the fact that the services were limited to begin with.

The provincial eating disorder network of providers has responded to the current cuts by directing patients from underserved regions to already strained specialized adult and pediatric programs like those in Ottawa and Toronto. This has led to unacceptably long waiting lists for intensive treatment of clients who are often young and extremely ill. The current health system deficiencies have taxed professionals to the point where they are finding it harder and harder to be effective practitioners in the care and treatment of the growing number of sufferers.

Anorexia has the highest mortality of any mental illness. Several of those clients who have been waiting for treatment have died while waiting. Others have travelled to treatment programs in the United States and, upon their return to Ontario, experienced an interruption in their follow-up care because of the same long waiting lists that drove them south of the border. This leaves them vulnerable to relapse and subsequent readmission to treatment programs here and in the United States.

Clearly, it is not just the patients' conditions that are unstable; the health system is also in crisis. By making eating disorders a special provincial program, there is a far greater chance that appropriate capacity-building to deliver evidence-based care can take place in a more efficient and responsible manner. If the responsibility for eating disorder treatment is delegated to the LHINs, I fear that the existing, albeit limited, specialized services that are presently being offered within a provincial network of eating disorder providers will be lost. In my opinion, a provincial program would be the best health care structure to deliver timely and uniform access to treatment to those nine-year-olds up to 50-year-olds from across the province who present with eating disorders. I

would appreciate hearing from this committee as to whether a provincial structure for eating disorder service delivery is being considered.

I'd also like to know how peer groups, like Hopewell, that have been shown to provide a valuable and necessary service to our communities—and given that those groups are not provincially funded and, therefore, do not come under the umbrella of the LHINs—will be included in discussions around local health system planning.

My parting comment is that our daughter Bridget, who is now 20, is physically healthy and learning to live with her obsessive-compulsive disorder and her learning disabilities. She's one of the lucky ones. There are far too many women out there who continue to struggle on a daily basis. Eight years ago, at the age of 12, when she was diagnosed with anorexia, there were no specialized services in Ottawa. As a result, she had numerous, lengthy—and by "lengthy" I mean six- to eight-month admissions over a three-year period. She lost a year of school, most of her friends and all of her confidence. With the assistance of many skilled and committed professionals she is finally, at the age of 20, eight years later, reclaiming her life.

As I said at the outset, eating disorders are complex and require the intervention and expertise of specialized multi-disciplinary treatment teams. To ensure that every child, youth, young adult and adult has access to this type of care, I believe that eating disorders must come under a special provincial program.

0940

The Chair: Thank you. We have 30 seconds each. I'll ask Ms. Wynne.

Ms. Wynne: Thank you very much for being here this morning. I certainly share your concern about the need for a coordinated approach to this disorder. Do you feel, though, that with at least having the beginnings of coordination with the development of the LHINs, there's the possibility that there will be a discussion about some of these issues that doesn't happen now? Because there really isn't coordination within the health system. I'm not aware of a special eating disorder program that's in the works, but it seems to me that the development of the LHINs is a good step towards having a more coordinated approach. If we don't know what's going on in our local areas or our regions, we're not going to be able to coordinate what's going on around the province. So do you think that the LHINs are a good step in terms of physicians and other health practitioners being aware of what the gaps are in their own areas on issues like this and on others?

Ms. Curran: Perhaps the best way of responding to this is to describe to you what has happened over the past year and a half. In 2004, a proposal was submitted by this provincial network of eating disorder service providers to the ministry. The ministry came back and asked for an emergency proposal. At that time, all of these programs that are involved in this provincial network—all of them—required funding, but they set aside their personal needs and looked at the benefits to the province at large

and developed a proposal where certain programs would be beefed up, for want of a better word, recognizing full well that their own local programs would not be getting the funding by supporting the investment of dollars in these other programs. That provincial network of service providers that is an informal group has been very effective, I believe, in addressing the needs of the province as a whole.

The Chair: Thank you, Mr. Wilson.

Mr. Wilson: Thank you, Ms. Curran, for your presentation. In terms of the group you're talking about, are they providing direct services?

Ms. Curran: They're providing direct services. I'm not talking about the network of peer support groups.

Mr. Wilson: That's what I was going to ask you. The front page, that's the peer support groups?

Ms. Curran: This group is different from what I mentioned, yes.

The Chair: Thank you, Ms. Martel.

Ms. Martel: It's nice to meet you in person. Let me just follow up where you were ending off, which is that the provincial eating disorders network is highly organized; there is no duplication. The application that went in to the ministry that long time ago has yet to be funded, despite me raising two questions in the Legislature this fall about it. What the provincial disorders organization needs is money, cash, so that we have a full continuum of services. There is nothing in the LHIN legislation that's going to fix that and there's no need for more coordination or a look at duplication because there isn't any duplication and the system is highly coordinated. What it requires is approval of the application.

If this doesn't get dealt with quickly, in terms of approval, what's going to happen to the services, albeit very limited, that are now in place, particularly for women, who have such desperate needs?

Ms. Curran: They will be cut back, as they already have been. And they are limited to begin with.

The Chair: Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 479

The Chair: The next presentation is from the Ontario Public Service Employees Union, Local 479, Royal Ottawa Hospital. Good morning.

Ms. Marlene Rivier: Good morning. My name is Marlene Rivier. I'm a health professional working in mental health.

OPSEU Local 479 represents the nearly 200 health professionals at the Royal Ottawa Hospital. We are among the 30,000 health care workers represented by OPSEU in this province. The facility in which we work is also one of the first P3 hospitals to be constructed in Ontario, but that's a discussion for another day.

We are grateful for the opportunity to participate in this public consultation with respect to a bill we believe has the potential to fundamentally transform the health

care system in a manner undermining of the principles of the Canada Health Act. Publicly funded health care services as set out in the Canada Health Act reflect fundamental Canadian values, and the preservation of these principles is essential for the health of Ontarians now and in the future.

Who pays the price for health services restructuring? Let's start with patients. Ontario, like the rest of Canada, is experiencing increasing income disparity; the rich are getting richer and the poor poorer, the gap between them ever widening. This is a disturbing trend in a prosperous province, the economic engine of Canada. Poverty, specifically income inequality, is the most powerful determinant of health, and the negative consequences for population health in this province are inescapable.

In the absence of income equality, social programs are the great equalizers, mitigating some of the negative impacts of poverty. Chief among these is our public health care system. When this system is weakened, population health suffers and the economic consequences are costly, though not necessarily immediately apparent. The human toll is impossible to measure. Middle- and especially low-income Ontarians have borne the brunt of health services restructuring, and they will continue to carry the burden of the LHINs.

This is not the first time patients in our community have had to deal with the impact of major health system restructuring. During the Harris government the HSRC directed sweeping changes to take place in our community. Two hospitals were closed and a third sought recourse to the courts in order to assure its continued survival.

The Salvation Army Grace Hospital served a community which included many low-income families. Its loss has been deeply felt. Promised community investment, which was to precede hospital closures, never materialized, but the closures went ahead, leaving residents in this community with reduced access to needed health care.

The Montfort, a unique cultural institution within the health care system, was slated for closure, despite the fact that it met the unique needs of the francophone community. In an apparent effort to reduce duplication, the kind of large-scale restructuring carried out by the Harris government and provided for in Bill 36 threatens a form of health care homogenization which fails to recognize the unique needs of linguistic and cultural groups, inner-city communities, women, aboriginal people, etc. These are needs which must be taken into account in providing effective health care.

The concentration of services in particular facilities which are deemed to provide a service at an acceptable cost has the effect of denying local communities comprehensive care and transfers the cost of health care from the public system to the individual, regardless of the ability to shoulder those costs, producing a two-tier system with regard to access to reduced services. Low-income Ontarians will not be surfing the net to find the facility in another community that can offer a needed service in a more timely fashion—they simply can't

afford it. This reduced access to services will be hard felt by middle- and low-income Ontarians, who will either experience financial hardship or simply go without needed services.

The directives of the HSRC have not been fully implemented in our community, and the prospect of further restructuring is quite daunting. Under the HSRC, the decision was made to centralize all mental health emergency services in the remaining general hospitals, resulting in the closure of the psychiatric emergency service at the Royal Ottawa Hospital. The unique character of this service was not recognized, nor the seamless service provided to ROH patients, who now must present at a general hospital for emergency admission. This has been experienced as a great loss by patients and families. Again, the promised dedicated services at the general hospitals have never been fully realized in favour of a homogenized approach to mental health emergencies.

Another group that's affected, of course, is workers. In order to be maximally efficient, workers need to be free of the worry as to whether they will have a job from day to day or who their employer will be. The loss of productivity, not to mention the toll on the health of workers associated with continuous instability, cannot be underestimated. Instability appears to be much of what Bill 36 has to offer with its continuous restructuring of the health care system. The chronic shortage of health care professionals is exacerbated by this threat to employment, which will only aggravate current challenges in attracting workers to these professions. Remote communities, as always, will be hardest hit by these recruitment and retention problems. The province needs to commit to develop through negotiation and to fund human resource labour adjustment plans that will include, at a minimum—and I won't read them out to you.

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An integrated system without physicians? Of all the perplexing omissions from this plan to integrate the health system, such as ambulance services and public health, none is more perplexing than the exclusion of the gatekeepers of the system: physicians. Much of the inefficiency in the system can be traced to cumbersome mechanisms between physicians and other health care providers and institutions. More efficient and integrated services for patients is a value for all health care providers and cannot be accomplished without the involvement of key providers such as physicians.

Disintegration in mental health: The inclusion of some aspects of mental health service provision and the exclusion of others—i.e. the psychiatric hospitals under direct control of the MOHLTC—precludes true integration of mental health services, whose uniqueness is again not recognized by Bill 36.

What about the real cost drivers in health care? Surely, a significant interest in putting forward this legislation is the control of health care costs, and yet the chief cost drivers are not addressed. Drugs are the fastest-growing cost in the system. This industry stands outside the system and is driven entirely by market forces, to the

detriment of patients, especially low- and middle-income earners. Clearly, no relief is in sight.

Privatization, another chief cost driver, is conspicuous in its absence. In fact, there is considerable concern that this bill favours privatization and facilitates it. The problems faced by our system, such as wait times and shortages, will be exacerbated by further privatization. As an example, the availability of home care to patients in our community has been severely undermined by the privatization of this key service and particularly by competitive bidding.

So what is needed? What is missing? First of all, transparent language. There is little that is local in the LHINs: vast geographic regions increasingly remote from the communities they serve, with inadequate or non-existent mechanisms for local control and input; lack of accountability; centralized exercise of expanded powers on the part of the minister; and minimal public consultation.

We need to know what the plan is. We need an articulated vision of the system. We need to address the revenue-generating problems inherited from the Harris government's ideologically-driven tax cuts, which robbed government coffers of \$13 billion, to support our public services and spare an already efficient health care system from further efficiencies. We need to feed and fine-tune the system, not dismantle it for sale to the private sector. That is something low- and middle-income Ontarians cannot afford. More importantly, we need to look beyond the budget cycle and the election cycle to set policy that will secure a health care system for the Ontarians of today as well as the Ontarians of the future.

The Chair: Thank you, madam, for your presentation. We have a minute-plus each. Mr. Arnott?

Mr. Arnott: Thank you very much for your presentation. You've outlined a number of concerns about the bill and also a number of your organization's concerns about health care in general. If the Minister of Health were here today and you were in a position to give him some direct advice as to what he should be doing in the next six months, what exactly would you tell him he should be doing?

Ms. Rivier: I would advise him to put a hold on this process, to be more transparent, to seek input from those who will be affected by it, and to rethink this plan.

The Chair: Ms. Martel?

Ms. Martel: Thank you for being here today. This community has already seen a great deal of upheaval through the restructuring orders, which would have had both an impact on workers and, ultimately, the patients they were trying to deliver service to. There is no human resources plan anywhere mentioned in this. There is going to be significant upheaval. What do you think that's going to mean, both for workers, who've already gone through one long round, and, more importantly, for the patients who are trying to get services from those same staff?

Ms. Rivier: I can't underestimate the amount of time that is lost from work when people are fretting about

whether they have a job and who their employer's going to be. You can't underestimate that.

I guess in my worst moments, I imagine that the lack of human resource planning is not accidental. We're all aware of the fact that there's at least a 20% differential between health care professionals working in the community and those working in hospitals. In my worst moments, I imagine that this is really a mechanism for degrading the economic lives of health professionals, taking away their jobs in hospitals and forcing them to accept low-paying jobs in the community.

We fought hard for what we have. We provide, I think, a very valuable service, and we deserve to be recognized for it. I don't think that we deserve to see the years that we've put into this system disregarded. We don't deserve to lose our pensions, our hard-fought wages and benefits. But really, that is the direction we're moving in. An enormous amount of energy went into constructing the human resource plan in Ottawa. I was part of that negotiating team. But it meant that we went from a projection of 2,000 layoffs in this city to a handful, and that reduced toll cannot be undervalued.

Everything eventually affects patients. If workers are distracted and distressed, that interferes with their ability to give the high-quality service they want to give to patients.

The Chair: Mr. Ramal.

Mr. Khalil Ramal (London—Fanshawe): It's nice to see you again.

About what you said in your committee presentation—just quick questions. What has led you to believe that this bill will be against, or doesn't speak of, the unique needs of linguistic people, cultural groups, aboriginals, the francophone community etc., since the ministry and the minister himself had an open dialogue with the francophone community, with aboriginal people, with many different stakeholders across the province of Ontario? That's my first point.

The second part: I wonder if you listened to the opening statement of the minister on Monday, when he said clearly, to all the people of the province of Ontario, in front of this committee, "No privatizations, no hospital closures, no two-tier health care." What's your answer to that?

Ms. Rivier: First, if you can remind me of your first question. With two questions, it's hard to remember it all.

Mr. Ramal: We had open dialogue with the aboriginal and francophone communities.

Ms. Rivier: Yes; thank you. The reason I have concerns about that is because, first of all, we saw it in the round that Harris carried out. Secondly, when the focus is on consolidating services and avoiding duplication of services, there is a great danger that the unique value provided by small providers, who are tailored to individual communities, will be lost. I am really concerned about something as simple as, say, cataract surgery. We have this hospital here who can do it very, very efficiently. But if there are people from particular communities who don't feel the relationship to that institution and that institution does not understand their special cultural

needs, they won't get that service; they won't go there. That's a reality that needs to be addressed. We cannot simply homogenize the system in an effort to save money. Sometimes there are multiple providers for a service because they provide it in a unique way that is essential for those communities and is essential to them actually getting the health care they need.

In terms of privatization, unless I see explicit language that says that there won't be two-tier, there won't be privatization, I am not reassured. When we see that we are moving towards a model—

Mr. Ramal: The minister, in his opening statement before this committee, gave all the people—

Ms. Rivier: I've also heard the minister—

Interjections.

The Chair: Madam, you have the floor.

Ms. Rivier: The minister has said that he doesn't see a difference between sweeping floors in a hotel and sweeping floors in a hospital. To me, that demonstrates a fundamental misunderstanding of the uniqueness of the health care sector, that cleaners who work in hospitals have unique and complex responsibilities that people in hotels do not have. I see a race to the bottom implied in that; that we're all going to be brought down to the bottom, because the specialness of what is offered in hospitals is not recognized.

The Chair: Thank you very much for your presentation.

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ROYAL OTTAWA HEALTH CARE GROUP

The Chair: Next is the Royal Ottawa Health Care Group and the Royal Ottawa Hospital—Bruce Swan and John Scott, please. Good morning. You have 15 minutes total for your presentation and potential questions or comments. You can start any time you're ready.

Mr. John Scott: Thank you, Mr. Chair. My name is John Scott. I'm chair of the Royal Ottawa Health Care Group. I'm accompanied by Bruce Swan, our president and chief executive officer, and also Kathryn Hendrick, who is behind me, our vice-president of communications and public affairs. Thank you very much for the opportunity to meet with you as members of the committee reviewing the legislation. We've handed out some material, which we will leave with you, but I'd like to provide a quick overview on that and then turn it over to Bruce to talk about some positive suggestions that we would like to put forward to the committee.

The Royal Ottawa Health Care Group comprises two teaching hospitals in Ottawa and Brockville associated with the University of Ottawa and Queen's University. We are unique in a way because we span two LHINs, the Champlain LHIN and the South East LHIN. A fact that so many people don't realize is that 60% of our care is already given in outpatient or community-based support. We also have within our system the Institute of Mental Health Research, which is the third-largest mental health research institute in Canada.

With respect to LHINs, we've taken the opportunity already to meet with Michel Lalonde, the chair of the Champlain LHIN, and Rob Cushman, the CEO, as well as Paul Auras, the chief executive officer of the South East LHIN. We've extended an invitation to Michel and to Rob to attend an upcoming board meeting to meet not only with our board of directors, but we will be inviting the senior representatives of all the stakeholders within the mental health care field so that we all have an opportunity to dialogue and to better understand the potential that is available to us within the LHIN system.

On that note, our approach as a board of directors is that LHINs provide us with an opportunity. Mental health, unfortunately, is the very poor cousin within the mental health care sphere, but it is pervasive. You heard earlier about eating disorder difficulties and whatever, but it is pervasive and is linked to most other medical problems that people face in their daily lives. So there is a need for very, very strong community support, but also support within the community.

We have gone through significant transition as the Royal Ottawa Health Care Group, and our mandate has changed in the last five to six years to move toward a tertiary care facility, so there has been significant upheaval. But we have progressed as best we can and in the most transparent way, and we look at the LHINs opportunity as an ability for us to better connect with the community and, most importantly, because of the legislation, to address the needs of our patients.

I want to say quite openly that we support this legislation fully. The reason for this support of the legislation is, first and foremost, that the patient is at the centre of the intention of this legislation. It promotes proactive, systemic change; it encourages and breaks down barriers to integration and partnership-building; it focuses on the full continuum of care for patients; and, by being community-anchored, it opens up the opportunities for education and support at the primary care or family physician level. Again, that was one of the comments that was made by one of the earlier presenters. We look at this as the opportunity for us to be able to be involved in the system at an earlier stage and hopefully enhance the betterment of the patients within our system.

We do have some suggestions for your consideration, Mr. Chair. With that point, I'd like to turn over to our chief executive officer. There are four points that we would like to briefly address: One is removing what we consider a perceived potential barrier for partnership integration; the second is looking at the provincial planning forum within the LHINs; the third is cross-LHIN service delivery needs—as I mentioned a few moments ago, we span two LHINs; the fourth is the role of multiple ministries involved in delivery of health care.

Mr. Bruce Swan: The proposed LHIN legislation promotes systemic changes and will advance the collapse of silos in the health care sector. For mental health services, it means that the hospital role—that of the Royal Ottawa Hospital and the Brockville Psychiatric Hospital—has an opportunity to change from an in-

stitutional facility for mentally ill persons to a health care centre which advances research in behavioural and neurosciences, program evaluation, the education of future mental health clinicians, and a continuum of care that reduces duplicity of service and fills in the cracks.

LHIN legislation ensures that the hospital is but one player in a system of mental health providers. It is our position that the term “hospital” for psychiatric facilities should be changed to “mental health centres.” This better reflects the role of the facility within a LHIN and allows for a level playing field for all partners in the continuum of care to link service deliveries in a network.

The critical mass of specialists in mental health will need to provide resources across more than one LHIN. There are efficiencies to gain in having LHINs work collaboratively in mental health so that specialized but limited resources are available more broadly. The Champlain Mental Health Network and the South, East Mental Health Alliance are working now on systemic changes that will create a mental health system that provides patients with an array of services that meet their needs. The goal is to provide the right care, in the right place, at the right time.

The LHIN legislation calls for an approval process that imposes potential barriers for the expedient integration of partners. A request to integrate with a partner will be replied to within 60 days by the LHIN, and an opportunity to appeal the LHIN decision is open for an additional 30 days. We believe this is too prescriptive. Legislation should impact health providers who are not willing to integrate, not impose timelines on those who are. This approval process should be removed from the legislation.

Through the LHIN infrastructure, a provincial planning body for mental health services representing all 14 LHINs should be established to ensure that primary, secondary and tertiary programs are defined, accessible and resourced for the residents of Ontario. Primary mental health care needs to be supported and linked to the specialized or tertiary providers to access training and provide opportunities for research that advances therapies and service delivery. The majority of mental health diagnoses present in primary care. An integrated system, and LHIN legislation, should ensure that the tertiary providers work to support the needs of the primary health care providers.

Accountability agreements should be standardized for the delivery of mental health systems for the province of Ontario and for each of the 14 LHINs. Decisions on resource allocation, system planning, and referral and discharge planning should be done in multi-LHIN districts, with highly specialized programs such as forensic psychiatry, dual-diagnosed disabled and mentally ill, and children and adolescent mental health, viewed as provincial programs.

The mental health system requires the determined collaboration of multiple ministries, including the Ministry of Health and Long-Term Care, the Ministry of Community and Social Services, and corrections. If the

mental health system is to integrate successfully, the province requires integration as well. The mental health agenda should be formalized within these ministries and partnered with a provincial LHIN planning group. Thank you.

The Chair: We have about six minutes left—two minutes each. We'll start with Mr. Wilson.

Mr. Wilson: Thank you for your presentation. You spoke on the last page here about section 28, the integration by the minister. I'm just giving my bias here; I'm the one who set up the Health Services Restructuring Commission as Minister of Health. This is 14 health services restructuring commissions. This is more power than I had. In fact, I had no power under that; that was given to the independent commission. The minister has 14 health services restructuring commissions, with more power than Bill 26 ever gave. The only safeguard is this 30-day debate period, although that will depend on the mood of the minister, I guess, as to whether he's going to debate. Do you want to comment on what you meant there?

Mr. Scott: Yes, I can comment. I am referring specifically to section 27, not section 28. Section 27 deals with the health provider who is coming forward with an integration plan that's already been agreed to with another partner. The legislation at this point imposes a 90-day hold period on that process. Now, when you've got willing providers in the community who want to go forward, then the issue here is, is 90 days a fair and reasonable period? Perhaps it is, but we're suggesting that there may be opportunities for that period to be reduced, because in the health care sector it may be important to move forward with a very positive and proactive community-based integration plan that's agreed to by the health providers within the LHIN environment.

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Mr. Wilson: Well, if it's voluntary integration, why do you need legislation? Why don't you just do it now if it's the right thing to do?

Mr. Scott: But under this, it requires that if we're provided with health care funding, then we have to give notification to the LHIN and allow them the 60-day period to decide whether or not they're going to prevent us from doing it. It would be wonderful, for example, if the LHIN would provide the support within two weeks or 30 days or something, but we anticipate that they're going to be very busy, so there is that 60-day period. Then you have to wait for a further 30-day period to see whether or not there is any other objection that comes forward. So I'm not talking about the minister or the LHIN's ability to do things with respect to other sections under the act. It's geared at where it's a voluntary, proactive, community-based suggestion with respect to integration.

The Chair: Thank you. Madame Martel.

Ms. Martel: Thank you for being here today. I want to focus on your comments that the LHIN legislation, with respect to mental health services, is going to mean that the hospital role, that of ROH and BPH, is going to have an opportunity to change, and you listed the change

as moving from an institutional facility to a health centre that advances research, etc. What's the barrier now for you to do that? Why do you need LHIN legislation?

Mr. Scott: Well, if I may, Bruce—and you may have some comments—I'm talking as the volunteer chair and not as the chief executive officer. I think that it's probably recognized that there are currently silos within the system, unfortunately. Notwithstanding the best interests of the hospitals, the community providers and whatever, in terms of the requirement for us to get on with what we're doing, it doesn't allow us to lift up our eyes and to look more at the collective community support that we can give. This legislation, the way we interpret it, is effectively encouraging, promoting, is giving us that mandate to work in a better continuum-of-care environment, as I said before. We look at it as a complement, a supplement and a direction.

Ms. Martel: But what are the concrete barriers now that stop you from doing what you want to do that will be changed with the LHIN legislation?

Mr. Scott: Good point. The concrete barrier is the direction that we're getting. One of the key issues right now is, we're working with the Ministry of Health and Long-Term Care as a centralized body. The intention of this legislation is also to bring it to the LHIN environment, which allows us the opportunity within our community to deal directly with the LHIN—as I said, the chair, the LHIN board and the CEO—and talk about the things that are very specific and related to us within our community. The comment was made by Mr. Wilson that this is 14 ministries of health, if you want to call it that. Yes, it is, to a certain extent, but they allow us to deal with it at the community base, a much more localized environment, and be able to have a better forum to be able to have these discussions, we feel.

Ms. Martel: Okay, but if it's—

The Chair: Thank you. Mr. Patten.

Mr. Patten: Thank you very much for coming today. I've seen the evolution of your organization over time, from being an institution in which people spent a lot of time to looking at your whole role in the community. I'm quite familiar with the development of the ACTT teams and the role that the health centre plays throughout eastern Ontario. So it would seem to me that there is potentially here a convergence of encouraging a culture of sharing, co-operating and integrating that should help the rural area in particular, where, in the past, the services tended to be centred in the urban centres and people in the rural areas were—I have a two-point question. One is, if we talk across ministry boundaries or with other community organizations, who would you see as some logical partners that you would look forward to talking to in terms of your role? Secondly, do you see the LHINs as being supportive of what I think is your intent: to strengthen your role on a regional basis, not just on a city basis?

Mr. Swan: First of all, I think the forming of the LHINs forces us to look at the population we serve. We do serve eastern Ontario, and as to your comment about maybe being more urban-focused, I think that has been

the tradition for mental health, particularly the old provincial hospitals.

As far as the legislation is concerned, I think it enables us to integrate with our partners and pay close attention to the population we're here to serve. Within health, our partners outside of hospitals are those like the Canadian Mental Health Association, Salus, some of the housing support organizations. Across ministries, it's child and family services. There are issues with child and family services; they actually do a lot of mental health, as we do. We are the tertiary or the more complex part of the mental health system. With corrections, about 50% of our work comes through corrections, so we have a partnership with them in Brockville. We operate a 100-bed jail that's a schedule 1 hospital.

Basically, there has to be dialogue across ministries, and what we have found with some of the work we've been doing is that there are barriers within each of our ministries that need to be eroded. We see the LHIN legislation and the forming of the LHINs as an enabling body that helps us keep our mind on integration. In mental health's case, it goes beyond health, because there are so many other ministries that are involved that are also providing mental health service.

Mr. Patten: Just a very quick follow-up: What about the Ministry of Education, the implementation with high schools and elementary school programs through the school system, where of course many—

Mr. Swan: Actually, in a full continuum of service, we would be linked with education as well. When we refer to the continuum, that's the supports that would go into the education system.

The Chair: Thank you very much for your presentation.

ONTARIO COMMUNITY SUPPORT ASSOCIATION, OTTAWA

The Chair: We'll move to the next presentation, from the Ontario Community Support Association, Ottawa, Valerie Bishop-de Young. Good morning. Bonjour.

Ms. Valerie Bishop-de Young: Good morning, Mr. Chair and members of the standing committee. Thank you for the opportunity to speak with you today. My name is Valerie Bishop-de Young. I'm here representing the Ontario Community Support Association—the acronym is OCSA—and I sit currently as president of the board of directors.

A bit of background: OCSA supports, promotes and represents the common goals of its member organizations, of which there are approximately 360. Member agencies provide not-for-profit health and social services that help people live at home in their own communities. Our vision is that Ontarians will be served with a well-funded continuum of quality community support services delivered by the not-for-profit sector.

Our members span across the fulsome heart of the province. They are community-based. Our members provide demonstrated economic value added to the health

care system. The University of Toronto supports this and has provided data, evidence, to say that \$1 of public investment is equal to \$1.50 of product; that is, service. We represent 25,000 staff and over 100,000 volunteers who work to help adults, seniors and people with disabilities to remain independent in their local communities.

Staff and volunteers work together to provide services such as Meals on Wheels, personal support and home-making services. As much as other parts of the health care sector will attest to being the unsung heroes and underfunded and unknown, community support services virtually represent that reality. We are the band-aid of the health care system. Meals on Wheels allows people to stay at home in their own homes. Respite services to family and caregivers—those numbers aren't represented in a hospital environment. Many of our members also provide services through the purchased service contracts associated with community care access centres, CCACs.

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Page 4 of my presentation gives you an overview of OCSA's position with respect to LHINs, and that is that we support reform of the Ontario health care system and that the needs of patients—in our sector we refer to them as clients—and local communities come first. We look forward to working with our health care partners to move towards an integrated system that emphasizes self-care, prevention and accessibility to services at the right time in the right place. Our member agencies have many values in common with the transformation agenda: equitable access to service, a client-centred approach that preserves client choice, results-driven outcomes that are rooted in a provincial strategic business planning process, and transparent accountability.

We believe there are some keys to success for Bill 36. Those include a strong, overarching foundation and the principles of ensuring accessibility, transparent accountability, service comprehensiveness and public administration, elements that are reflected in the Canada Health Act and Ontario's Commitment to the Future of Medicare Act.

Consultation provides for constructive exchange of opinions and information, and it is critical for buy-in of the key components of the health care system. Meaningful dialogue must be realistic in its assessment of the facts. Critical targeted investment is required to ensure the health care system has the fuel—that is, the skilled human resources—to do the job that's necessary. No structure, LHIN or any other, will be successful without the necessary support of key players and the necessary resources.

Comprehensive dialogue looks beyond traditional system silos; that is, how are other scarce resources such as volunteers and unregulated care providers accounted for and supported? Critical investment is needed to ensure recruitment, training and active engagement of the value-added volunteers and of the unregulated care providers who increasingly, given the shortage of regulated providers—that is, nurses and therapists specifically—are providing the care that our aging population demands.

We ask that the LHIN legislation have due consideration for the value of volunteers, that the legislation recognize and encourage volunteerism. In order to be true to the philosophy of system thinking, the community support sector in each LHIN must be part of the decision-making process regarding integration and the development of the local integrated health service plan. Recognizing the value of volunteers is more than just good politics. In health and community support services, it's good economic value.

A broad culture of integration can only be driven by a clear provincial plan. A provincial plan needs to include processes and practices that can be measured and that support the smooth transition of clients within and across sectors. System navigation is not a job description in its own right; it is the job function of every health care worker.

At OCSA, we believe that every door is the right door. Our vision for LHINs is based on the adoption of the broad determinants of health where people are supported at the first point of access, wherever they enter the health care system. Comprehensive primary health care includes community support services as key participants, and it is key to transformation. The community support sector is very often the first point of contact for clients. Personal support services, community services and home care are the key to preventing unnecessary and more costly interventions, such as visits to the emergency room and unnecessary hospital stays. Supporting a client through the system smoothly, following the most direct route and reducing bureaucracy is just good integration practice.

Effective and efficient management at the local level of LHINs: Community support services help keep clients out of those ER rooms. Events like a fall that bring people to the ER can be avoided with adequate supports in the community. We see ourselves as very clear partners with hospitals in every LHIN, that we work together to ensure that everybody gets the care they need, where they need it, effectively. Countries with the best health outcomes and the lowest expenditures of GDP have strong primary health care systems, and that includes home and community care.

Community support services are a good investment, and they can help the system live within its means. There are many studies and much evidence that speaks to that, most notably the research by Dr. Marcus Hollander here in Canada. Community support services can provide care for much less than any other part of the system. I've given you the data on page 11 of my presentation.

Our concerns and our recommendations with respect to Bill 36: Number one is with respect to the local health advisory committees. While the legislation—Bill 36; the act itself—focuses on breaking down silos, local health care advisories that are limited to regulated professionals in fact reinforce silo existence, and do so at the highest level by providing advice to the decision-making body of the LHIN. We ask that consideration be given to expanding local health advisory committee membership to include representation of the community support sector at the table.

With respect to accountability agreements, the essence of LHINs is local responsiveness based on province-wide strategic goals. We recommend that the LHIN legislation speak clearly to the development of outcome indicators, and that those goals are articulated in a clear—established, first and foremost, before outcomes—provincial strategic plan, and that the plan understands and appreciates that “local knows best” solutions often respect local strengths and facilitate health system effectiveness.

In terms of effective and efficient services, we ask for clarity of language, please. We recommend that “efficient” and “effective” be defined in the legislation, but that they recognize the value of quality outcomes—the numbers game doesn't always represent the full picture; that the components of innovation and flexibility are recognized; and community responsiveness, including the degree of community involvement and support inherent in service provider operations. Clarity of the language will reduce ambiguity and remove opportunity for selective application.

With respect to part V, section 28, the discretion of the minister to force integration, the legislation specifically proposes the option of forced integration for not-for-profit organizations. We feel that that authority should be extended to all funded health care providers who receive public funds, or to none at all. We are unclear as to why the not-for-profit sector has been targeted in this fashion. It certainly seems to make sweeping assumptions with respect to the governance of not-for-profits, and it makes equal assumptions with respect to the governance of for-profit organizations. We would suggest that local accountability and funding accountability follow the dollars and not governance.

With respect to system navigation—system navigation, again, is not a job description in its own right. Every client has a unique set of needs, a different point of access into the system and a different path of processes and relationships to transition through. All health care providers have a role to play in helping the client or the patient through the system.

CCACs are broker organizations that purchase services on behalf of clients. We believe that there are unintended consequences of role expansion, up to and including overlaying of an expensive competitive model on top of effective, timely service delivery. We recommend that the bill limit the role of CCACs to their current position in terms of brokering for services such as nursing, personal support, therapies and medical supplies—that which they already do.

The Chair: Thank you very much. We did use the 15 minutes. We thank you for your presentation.

1030

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 460

The Chair: The next one is a teleconference from the Ontario Public Service Employees Union, Local 460, Kingston. Is Gavin Anderson on the line?

Mr. Gavin Anderson: Hello. Good morning from Kingston.

The Chair: Good morning, Mr. Anderson. You have 15 minutes total for your presentation. If there is any time left, we will allow some questions and/or comments. Please start any time.

Mr. Anderson: Thank you. My name is Gavin Anderson, and I'm the vice-president of OPSEU Local 460. Local 460 represents 85 front-line clinicians and clerical staff who work for Pathways for Children and Youth. Pathways is a children's mental health agency that serves children and families in Kingston, Frontenac and Lennox and Addington counties.

I will speak about the relevance of the local health integration networks to children's mental health in a moment, but first I want to thank the standing committee on social policy for hearing my submission. I had hoped that the committee would convene for at least one day in Kingston, but I appreciate the opportunity to participate by speakerphone, and I trust that the transmission is clear.

I realize that most of the submissions you will hear will be delivered by individuals and organizations that are directly involved in the delivery of health care services or groups that advocate for patients or the Canadian medicare system. I know that my own union president, Leah Casselman, as well as many other elected union leaders have met with the committee and spoken with passion and conviction about the problems associated with Bill 36 and the LHINs initiative. The Ontario Health Coalition and local community health coalitions have also weighed in. It is not my intention to repackage their submissions, other than to reiterate that the unions and the health care coalitions make a convincing argument against the LHINs.

I agree with those who maintain that the LHINs have been poorly planned, without adequate consultation. I share the concern that physicians have been inexplicably left out of the equation. I believe that the LHINs are neither democratic nor accountable and stretch the boundaries of the term "local" beyond reason. These are serious challenges, and I certainly hope that the committee takes them to heart. It would be a grave error to proceed with the LHINs as presently contemplated.

I began by identifying myself as the vice-president of OPSEU Local 460. That is the credential that I used to request standing, but you should also know that I am a registered social worker at Pathways with a full caseload. I have arranged my schedule today so that I could call on my break. I have worked in children's mental health for over 25 years, the last 18 in southeast Ontario with Pathways and its predecessor agency. When my colleagues and I speak about children's mental health, we do so with the credibility and the authority that is earned through years of direct, dedicated service.

Many of you may be wondering about the connection between children's mental health and the LHINs, since children's mental health agencies, including Pathways, receive their funding from the Ministry of Children and Youth Services and not the Ministry of Health and Long-

Term Care. George Smitherman confirmed the connection on November 29 when speaking about Bill 36. He said, as reported in Hansard:

"We also believe that there are opportunities to move forward and create a broader role for community care access centres. Other government ministries have wondered—and we will work on this as a government; we will seek input on this—whether it might not be possible to use community care access centres not just as a place that's branded, if you will, related to the Ministry of Health, but with a broader service role. Taking a look at other community programs that are delivered by sister ministries, like the Ministry of Children and Youth Services, the Ministry of Community and Social Services and even the Ministry of Education...."

Clearly, the government of Ontario is contemplating moving children's mental health and other community services into the CCAC model, which to my thinking will place these non-medical agencies squarely under the authority of the LHINs. Let me explain why that is threatening to my members and to the families that depend on our services.

Mental health remains poorly understood and chronically underfunded. Our colleagues who work in the adult mental health sector, including OPSEU members who work in psychiatric hospitals and psychiatric wards, have testified in this and many other venues about the bleeding of resources away from mental health services towards more easily measured and more easily understood medical procedures. In the LHINs model of allocating resources, adult mental health workers, patients and advocates will be competing for recognition and funding in 14 jurisdictions. Historically, the needs of children with mental health issues are even less well supported.

Children's Mental Health Ontario has estimated that as many as 558,000 children under the age of 19 have a diagnosable mental health disorder; that's 18%, or nearly one child in five. More than 300,000 are living with multiple disorders. Our experience is that it is difficult to get and keep the attention of even our own ministry. Our capacity to meet the needs of children with emotional and behavioural problems is shrinking when measured against the expanding demand for services.

We are also aware of the problems in home care, which under the CCAC model has degenerated into a fragmented sector of competing service providers that have disrupted continuity, eroded service standards and depressed wages. We do not want to see children's mental services going to the lowest bidder. We do not want to have to follow our work from employer to employer, as contracts are terminated and reissued to the cheapest alternative.

The children and families of Ontario need to have confidence that their government will provide access to adequately funded children's mental health services. This is a commitment that only a central government can guarantee. We do not believe that 14 LHINs will independently accept the same obligation, especially in the face of competition from services that historically have enjoyed far more political and community sympathy than

the services that support the types of misbehaving children and dysfunctional families that rely on our services.

The LHINs initiative is bad policy that has failed in other jurisdictions. The LHINs represent poor planning and incomplete consultation and deserve to be derailed on their own merit. Minister Smitherman's musings that the LHINs of the future will potentially swallow more agencies, including the one I work for, are just piling on. Please put the brakes on this potential train wreck before our health care system is thrown into further disarray.

I believe there is some time available, and I would be pleased to clarify any part of my presentation or answer any questions that anybody might have. Thank you for your attention and your consideration.

The Chair: Thank you. We have at least two minutes for each group. I will start with Madame Martel, please.

Ms. Martel: Thank you, Mr. Anderson, for joining us this morning and for taking the time to do so. I want to focus specifically on your concern around children's mental health somehow being taken up by CCACs, particularly in light of the chaos in CCACs with respect to competitive or cutthroat bidding. The government has tried to say, and the minister tried to say in his opening remarks on Monday, that there's nothing in the bill that says that LHINs will use the competitive bidding model to purchase or acquire services. I've pointed out to the committee on numerous occasions that there isn't anything in the bill that stops that, either. It's not explicitly written into the bill that this will not be the mechanism that is used for LHINs to acquire or purchase services.

Further, we heard from one of your colleagues earlier this morning, Ms. McSheffrey, who said that when she made a presentation before Elinor Caplan about competitive bidding, Ms. Caplan made a point of saying that she was looking at competitive bidding because it might well be the model used in the LHINs for the purchase of services. I remain very concerned that in fact this will be exactly the model that LHINs will use to purchase services, and the chaos that we've seen in home care will then be expanded across all of the other sectors that LHINs are responsible for.

Given your intimate work with children who have very severe needs and with their families who are trying to support them, if that model is applied and if you essentially are incorporated or attached to CCACs in a way that you aren't now, what is your fear both for the services that you're trying to provide and for the very vulnerable clients you're trying to give services to?

Mr. Anderson: I think you've phrased our concerns very well. We work with individual children, but it's always in the context of families. The work can go on for extended periods of time, sometimes continuously, sometimes addressing particular developmental stages or times in the family's evolution. It's critically important that there be continuity and stability within the service providers. We need to attract individuals to this type of work who can be confident that their loyalty to the field

will result in their having a career in the field, not like home care.

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I have friends in Kingston who worked for All-Care Health Services, who saw their contract lost. Many of them had to sign on again with new agencies and learn new protocols. That's exactly what will happen in children's mental health. That's the CCAC model now. So for the government to issue assurances that it won't happen—I think the best predictor of the future is the past. Unless the government renounces the competitive bidding process, which they had an opportunity to do when Elinor Caplan was doing her work and didn't do, then my members are afraid that that's our future.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you, Mr. Anderson, for joining us. I just wanted to make a couple of comments. I wanted to draw your attention to the front of the Globe and Mail today—just in terms of the model that we're trying to develop—that BC is being seen as the best health care system in the country, and we're trying to improve on that. That's the model we're trying to put in place.

I just want to make a comment about the Ministry of Children and Youth Services. The fact that our government has set up a ministry specifically to focus on children speaks to our commitment not to derail that focus, not to move children's services out of that coordinated area—

Mr. Anderson: If I could just interrupt and ask you then how you reconcile that with Mr. Smitherman's comments on November 29.

Ms. Wynne: Mr. Anderson, I have a question. One of the jobs I have is that I'm the parliamentary assistant to the Minister of Education. I've been very involved in a review of special education recently. I just wonder if you could comment on the crying need that I hear from people in the education sector, people working with children in special education, the need for more coordination among ministries around meeting those needs. It seems to me that having a LHIN in place that coordinates local health services and, I agree with you, is then able to help ministries work together—MCYS, education and health—will be a good thing for children with special needs and the children you deal with. Could you comment on that?

Mr. Anderson: Yes. Coordination would be a good thing. I'm not here to criticize anybody who wants to integrate or coordinate services. The gist of my presentation is that there's a hierarchy in terms of what services get funded. We need a province-wide central government commitment to children's mental health and the issues that challenge the families with children with mental health issues. Integration is fine, but my worry is that in 14 jurisdictions, children's mental health—and adult mental health, for that basis—will be a low priority. So coordination without adequate funding really isn't helping the situation.

Our anxiety is that the minister is suggesting that the CCAC model will come into children's mental health.

Regardless of the integration possibilities, the threat is much larger than the opportunity.

Ms. Wynne: But, Mr. Anderson, there's nothing in the bill that says that. So thank you very much—

Mr. Anderson: There's nothing in the bill that allays our fears.

The Chair: Thank you, Mr. Wilson.

Mr. Wilson: Thank you, Mr. Anderson, for your comments. Just following up on what my colleague from across the way has been saying: First of all, I just want to say, don't anyone be fooled by the Globe and Mail article today saying that BC's the best health care system. Ontario and BC aren't even comparable in terms of complexity and the volumes we do. Also, keep in mind that OHIP's the largest single insurer on the North American continent. I don't think much is comparable. We're even bigger than all of the US insurance companies.

I would say that your point's well taken, that children's mental health services have often been the poor cousin in health care. Because you have these fears—and there certainly are a number of sections in the act, about seven of them, that deal with getting rid of not-for-profit organizations and so-called integrating them; they seem to be singled out—will you or OPSEU or children's mental health services people be putting forward amendments to give you some safeguards that there'll be, for example, as you make the point, a province-wide mental health program in place before these integrations start?

Mr. Anderson: I would hope that OPSEU and the unions are doing that. It's my understanding that we have written submissions as a central union that are following these presentations. I'm afraid my purview's limited to my little local in Kingston and to let you know the anxiety that some of the community agencies are feeling.

Mr. Wilson: Don't hesitate to think up an amendment. We'll help you with the legalese of it.

Mr. Anderson: Okay. I appreciate that.

The Chair: Thank you, Mr. Anderson.

OTTAWA HOSPITAL

The Chair: We'll move to the next presentation, which is from Ottawa Hospital. There are a number of individuals speaking. Good morning.

Ms. Peggy Taillon: Good morning.

The Chair: You can start any time you are ready. You have 15 minutes.

Ms. Taillon: Great. Thank you very much. Thank you all for having us here today. My name is Peggy Taillon and I'm the vice-president at the Ottawa Hospital. I'm here today with our chief of medical staff, Dr. Chris Carruthers, who is also representing our board of governors today.

We certainly do appreciate the opportunity to speak with you. We'll declare our bias right from the get-go so that you get a sense of the thrust of our presentation today. Dr. Carruthers and I and the Ottawa Hospital are extremely supportive of the transformation agenda and

the direction this government is taking with respect to local health integration.

We put together some material in your package. A lot of it is for your perusal and some background. We wanted you to understand who the Ottawa Hospital is. So in the package you'll have a background and our strategic directions, which actually do speak to our commitment and contribution to the LHIN in the Champlain district.

In the presentation "Bill 36 and LHINs," page 3, slide 5 really sets out the Ottawa Hospital's perspective on Bill 36. Of course, we are very supportive of the transformation agenda. The position we take is that this is not just health care transformation; this is actually major social transformation in Ontario. One of the points that we'd like to emphasize with you today is that community engagement and engagement of the broader citizens in Ontario and awareness of this wide-sweeping social transformation need to be enhanced. We're going to talk a little bit about some ways in which we believe we can strengthen this transformation agenda, strengthen the LHINs and strengthen Bill 36.

Page 7, slide 14 really emphasizes the point. Any regional structure, any local governance: One of the key pillars to it is being local, being close to the citizens, the patients. We believe that Bill 36 needs to be strengthened in that the only true reflection of community engagement embedded in Bill 36 is a public board meeting. We believe that meaningful consultation, engagement and dialogue with your community so that plans actually reflect the unique needs of every community across the province—consultation and engagement need to be strengthened and the LHINs need to look at very practical ways to engage local communities and reflect the uniqueness of communities across Ontario.

We also think that the definition of "community" in Bill 36 needs to be expanded. We need to reflect, really, the diverse heritage of Ontario. By that, we mean linguistic, rural, northern, aboriginal, new Ontarians. We'd like to ask you to reflect on how the LHINs will improve the patient experience for those populations. Our previous speaker spoke to special populations, people requiring mental health services; we all know the demographics around the aging population. I think we need to think in practical terms about what LHINs will do to change their experience as patients, as citizens on the ground. We believe there are tremendous opportunities to do that through implementing this transformation.

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The legislation could be strengthened in the sense that it really doesn't define the health care system per se. It talks about it in very broad terms. I think this is an opportunity to clarify roles and responsibilities across the health care system. All of us in the health care system couldn't possibly even define all of our partners in care because there are literally hundreds. There are over 250 providers just here in the Champlain district.

I believe that the opportunity is to define in this legislation the four levels of care and very clearly articulate them: what is first-line care, acute, tertiary and quarter-

nary, and who are the providers—not specifically, but what are the types of providers that are found under each level of care and what are their roles and responsibilities respectively to provide care, so that we can create meaningful accountability so that people can understand which door they enter to get what types of service in the province. I think this is a real opportunity to do that, and I was disappointed to see that that was missing in the legislation.

Another piece that's key, and I'm sure you've heard it reflected in your consultations across the province, is that Bill 36 is silent on two key pillars of the health care system: health research, and that would include basic science research that's done in laboratories and clinical research that's done in our clinics and ORs, and education of future health professionals.

Research and education are truly the lifeblood of the health care system and are key to sustainability. Academic health science centres are the primary conduit for research and education and are not even mentioned in this bill, and we really would urge you to revisit and reflect that in this legislation.

The other point that I'd like to emphasize—and it was reflected, I believe, in the last speaker's presentation—is that health is really one pillar of Ontario's human services network. While the Ministry of Health and Long-Term Care embarks on this needed transformation, other ministries such as social services, children's services, justice, corrections and education are going to continue to work in their historical and traditional silos. I believe that this will weaken the gains that can be made through local health integrated networks. I would strongly urge the government to look at how to better integrate social services, and children's services in particular, with the local health integrated network strategy.

If there's any message that I could leave with you today: We need to keep this simple; we need to focus on people. Health care is all about people—the people who provide service, the people who receive service, and the people who are supporting the vulnerable people in our province. The focus to date has really been about organizations and structures, and I think we need to focus on the patient journey and what this change is actually going to do for citizens across Ontario. My neighbours don't even know that this major social change is occurring in Ontario, and I think that's something that all of us could improve on and really, truly engage them in a meaningful way.

With that, I'm going to ask Dr. Carruthers to speak on his points.

Dr. Chris Carruthers: I think you've got the handout. Just quickly on my background: I'm chief of staff at the Ottawa Hospital. I've been in practice for 30-plus years; an orthopaedic surgeon.

I want to focus on one issue. I recognize that there are a multitude of issues. I recognize that there are other issues to be addressed, but I think it's best to leave you with one message. Number one, I strongly support the direction of LHINs. I've supported it in the past; I've

written about it in the Ottawa newspapers and editorials. You're going in the right direction. As a matter of fact, we're behind. You need champions, and I want to show you how we can create more champions and make it successful.

I think there are key success factors, and one of the key success factors is having the physicians on board. I've learned an awful lot in a hospital where I have 1,200 physicians to deal with on a daily basis. If they're not on board, I'm not going to be successful in implementing what I want to do. I need them there.

Prior to this, we in eastern Ontario were ahead of the curve of several other districts. We already had a regional chiefs of staff association. This was a loose group of the chiefs of staff from all the hospitals from Pembroke to Cornwall who met on a regular basis and talked about issues, talked about the challenges in delivering health care, how we could do it. It was an informal relationship but it was a very beneficial structure.

What I see missing in the legislation is such a structure as we go forward. I think it should be embedded generically in all of the LHINs. Our group met successfully two to four times a year and talked about issues related to the delivery and integration of health care—not specifically physician issues.

I think one of the weaknesses—and I'll put a caveat on my remarks by saying I recognize that there are other important issues—is that there is no formal structure other than the PAC for physician input. Already, without such an inclusion, it risks indicating that the government has limited interest in physician involvement or participation. Such a formal structure is a critical success factor for the LHIN. Today, prior to the LHIN, there does not exist a formal structure where hospitals and other providers sit at a table and talk about how to best integrate the system. We do not sit down at a formal table and talk, particularly with the physicians, as to how to integrate the services. There is a professional advisory committee, but I don't think it is sufficient. Failure to engage physicians will lead to a potential failure, particularly of the implementation of integrated service plans.

So what would I recommend? Look seriously at creating a regional medical advisory committee. Don't forget that in the present structure the existing hospitals' MACs continue. So it's only natural that there is a roll-up of that over the LHINs. Such a structure was recommended when you look at Tom Closson's report on the integrated service plan for northwestern Ontario. They did a study. They looked at it and suggested that. It must be a meaningful structure with direct input to the LHIN board. A token structure will lead to physician apathy and non-collaboration.

Membership has not been decided, but it could be by both appointed and elected. It must be there to make the LHIN successful, not there as an obstacle or to obstruct the LHIN. This is the way to go. It would address other issues, though, that are important as we look at a regional

LHIN structure, such as medical human resource planning, and the advantages and risks of integration of clinical services. One of the key issues is looking regionally at the quality of patient care, looking at utilization management, common clinical pathways—so when you enter one hospital with a disease, it will be similar to the other—and provide communication, which is key.

So a LHIN-based MAC would provide the opportunity for LHIN physician leadership, the champions, for the benefit of the public and the medical community. Such a structure should be part of the LHIN legislation.

Those are my comments.

The Chair: Thank you. We have 30 seconds each. Mr. Patten.

Mr. Patten: Thank you for coming today. It's interesting. First of all, you're seen as the giant in the community, this powerful, huge hospital. So it's heartening to hear you talking about supporting something that is intended to be a leveller.

As I've been listening to some of the presentations this morning, I'm tempted to ask, how much money do people spend going back and forth to Toronto? MPPs have to do that, but how many people from hospitals, from health care centres and one thing or another, fighting for more resources: "You don't understand our area. The system is too centralized"? This is an attempt to say we've got to push some of that decision-making, responsibility and power back down to the region.

Now, I acknowledge that the region is pretty darned big, and that's going to be one heck of a challenge, but one question I would ask you is—and Dr. Carruthers, I appreciate your comment as well, and Ms. Taillon, you work on sort of the organization side of things and building systems—is there not room in this particular system for doctors to have an advisory role in and of themselves? I don't see anything precluding that, except formally, and this is an attempt to try and break down the traditional structures that have gone where, quite frankly, doctors have dominated the whole system. Well, it's a health care system; it's not just a medical system. I think this is the intent here. I'm being very blunt, but that's taking nothing away from my respect for doctors, believe me.

Ms. Taillon: Richard, I think that Chris reflects on the fact that in the Champlain district we've worked under tremendous goodwill, and the Ottawa Hospital has been committed to working with and enabling our partners in the district. We have a number of regional initiatives. We have lots of regional programs. We've moved out a number of services, created satellite programs in other smaller hospitals, and Chris has brought together a group out of goodwill in a very informal way. I think what he's seeking is formalization. There are all kinds of those groups out there, and I think that the LHINs need to think about what core advisory groups they need to give them meaningful advice on the ground above and beyond—again ensuring meaningful citizen engagement, which I think is critical and missing.

The Chair: Thank you. Mr. Wilson.

1100

Mr. Wilson: Thank you very much for your presentation. The regional medical advisory committee—I guess it's the first time, as my colleague Mr. Arnott, who's been attending all of these hearings, says, that we've got a label for what you're looking for. Certainly, we support that. I don't see why it's any sweat off the government's back—I think Mr. Patten was saying the same thing—to include an advisory committee; in fact, it's probably a very positive step.

I just wanted to say, since I was the fellow who brought in the Health Services Restructuring Commission and gave it independent but sunset powers—it went away after a while—with the exception of it, the only levers the Minister of Health has in the system are funding levers. This bill is a fundamental change in terms of the powers of the minister, who really brings upon himself or herself in the future tremendous new powers. You're away from funding levers to direct integration orders. Does that not concern you? You didn't mention anything, really, about the powers of the minister. It used to concern the OMA when I was minister, I can tell you that.

Dr. Carruthers: I'm not going to speak as a physician; I'm going to speak as a citizen. The direction this is going, the devolution of power, is very important. If you knew and understood the Champlain district, you would understand that this is one of the most collaborative districts that ever existed. The Ottawa Hospital may be a giant, but we work collaboratively with Pembroke, Arnprior and Almonte. So this can be a success. I think it's heading in the right direction. The other reason is, we have the key people in place to make this LHIN a very successful one.

The Chair: Thank you. Madame Martel.

Ms. Martel: Very briefly, you heard the concerns expressed by the previous speaker about where our mental health, particularly children's mental health, ranks in terms of priority. So how do you see the LHINs dealing with those very concerns?

Ms. Taillon: I was involved with mental health reform, actually under your government, heading up the mental health task forces in the province. So this is an area that's very close to me. The task forces actually recommended regional mental health authorities. We felt very strongly that health services needed to be reorganized. Mental health does not have a profile. There is tremendous stigma. There is a lot of misunderstanding and a lack of resources. We thought that having some local authority to start looking at how to best expend resources that are actually going to meet the needs, so we're planning for people instead of planning based only on policy that's very centralized, was something that was really needed. And we looked at evidence from the UK and right across Canada. We thought this was the structure that needed to happen to fill the gaps, for vulnerable people particularly, in the mental health system.

The Chair: Thank you very much for your presentation.

OTTAWA FRANCOPHONE
COMMUNITY LEADERS
LEADERS DE LA COMMUNAUTÉ
FRANCOPHONE

The Chair: The next presentation is from the Ottawa Francophone Community Leaders. There are five and we only have four microphones, if you can keep that in mind. Please have a seat. There is a total of 15 minutes for your presentation. Any time left will allow for members to ask questions or make any comments.

Mr. Gilles Morin: Did you say 15 minutes?

The Chair: In total, yes. That is what has been agreed. I would suggest that you may want to start your presentation quickly.

Mr. Morin: Before we start, I'd like to ask you—we came here as a group and we will be continuing with our presentation, so if the questions can be reserved for the end.

The Chair: Excuse me. We have already decided on the matter. Unless I hear from the membership otherwise, please start so you have more time for your presentation.

Mr. Morin: Monsieur le Président, members of the committee, it is crucial that there be no misunderstanding about what we have to share with you today. This is an extremely important issue for all Ontarians, but it is vitally important to the Franco-Ontarian community. Our health depends on it; so does our future as a vibrant culture that has flourished in Ontario for more than 300 years.

As some of you may know, I had the great opportunity to sit as a member of the Ontario Legislature for 14 years. And, like my friend Mr. Grandmaître, I had the pleasure of being part of Premier David Peterson's cabinet. I was also a member of the opposition, and it was obvious to me that you do not have to be in government to be useful to society.

This is one issue where we all have to work together to come together. Franco-Ontarians have had more than their share of battles over the last century to have their rights respected. We do not wish to battle over this. We ask simply that you try to understand what it's like to be a Franco-Ontarian and to be deprived of the health care services in French you are entitled to, and that you act on it.

Furthermore, we ask that you think of Franco-Ontarians not as an interest group, not as a group that wants and needs services in their language, but as one of the founding peoples of this country. Francophones were signatories of the 1867 constitutional pact that created Canada, and they would never have signed the Constitution if they had believed that their culture and language would not be protected throughout this new country. We're not saying it; the courts are saying it. This is what the Court of Appeal for Ontario wrote in the Montfort judgment: "The protections accorded linguistic and religious minorities are an essential feature of the original 1867 Constitution without which Confederation

would not have occurred ... The protection of linguistic minorities is essential to our country."

This is what the Supreme Court wrote in the secession reference: The Constitution Act of 1867 "guarantees to protect French language and culture" in Canada as a whole. You certainly do not protect French language and culture if Franco-Ontarians have no or little access to health care in their own language. At present, health care services in French are far from adequate. I will let other speakers address this issue more specifically.

During the 20th century the notion of a minority of francophones in Canada being a founding people, with all its significance and implications, was lost, and decision-makers, especially at the provincial level, governed as if the minority did not have rights equal to those enjoyed by the majority. But times have changed; things have changed: Franco-Ontarians now have their own schools and the governance of their school system; French is an official language in our courts of justice, where it is used routinely now; the French Language Services Act of Ontario was passed 20 years ago; and the Franco-Ontarian community applauds positive initiatives in health care such as the expansion of the Montfort Hospital, the investments in teaching for francophones and the development of family health teams.

However, practically everywhere else in the province, health care services in French have in fact deteriorated. The Franco-Ontarian community has not been protected. There is no doubt at all that this deterioration has had two dire consequences. First, Franco-Ontarians have been offered health care services of a quality inferior to those offered to the majority since they can't communicate in their own language. That is not best practice in health care. Second, the lack of health care services in French has increased assimilation, and government policies that have such an impact are squarely against the Constitution of Canada and the intent of the French Language Services Act. Ontario can do better.

Dear colleagues, more than half a million francophones live in Ontario. That's equal to the population of Newfoundland and almost four times the population of Prince Edward Island. It is also more than half of the one million francophones who live outside Quebec. Ontario must take the lead in providing adequate health care to its linguistic minority. If we can't do it here, it cannot and will not be done anywhere else in this country, and Canada will be lesser for it. In fact, Canada as we know it, with the richness of its linguistic and cultural duality, will eventually cease to exist; it is only a matter of time.

But if we all think of the francophone minority as a founding people and act accordingly, a lot of things should be givens. The government should actively seek to improve health care services in French. For all these good reasons, it is time to act. Let's make sure this law, this transformation of our health care system, treats the minority as it should be.

Merci. Je demande maintenant à ma collègue M^{me} Michelle de Courville Nicol, présidente sortante du Conseil d'administration de l'Hôpital Montfort, de prendre la parole.

M^{me} Michelle de Courville Nicol: Monsieur le Président, membres du comité, j'aimerais vous parler d'une question essentielle au succès de la transformation du système des soins de santé et au développement des services de santé adéquats en français pour la communauté franco-ontarienne de toute la province.

Laissez-moi vous dire clairement que chaque Franco-Ontarien possède autant le droit d'avoir accès à des services de soins de santé dans sa langue que chaque membre de la majorité. Évidemment, ce n'est pas la réalité présentement.

Il n'y a qu'une façon d'assurer l'atteinte de cet objectif que nous devrions tous avoir : fournir l'accès aux services de soins de santé en français à chaque membre de la minorité.

1110

Toutes les décisions touchant les francophones dans la planification et la prestation des services de soins de santé en français doivent être prises par des représentants de la communauté franco-ontarienne. Non seulement est-ce que c'est la meilleure pratique, c'est la loi.

Le gouvernement et le ministre de la Santé et des Soins de longue durée ont démontré une volonté de réaliser cet objectif, mais pour le moment, le cadre des réseaux locaux d'intégration des services de santé est profondément défectueux, et structuré de manière à échouer en ce qui a trait à l'élaboration et au maintien de services de soins de santé en français.

Chaque fois que cette question a été soulevée lors des ateliers sur les réseaux locaux d'intégration qui ont lancé cette initiative du gouvernement il y a plus d'un an, la responsable de l'intégration du système, M^{me} Gail Paech, a dit à plusieurs reprises qu'un groupe de travail présidé par M. Gérald Savoie examinait cette question et allait résoudre le problème.

En fait, nous comprenons que le groupe de travail sur les services de soins de santé en français présidé par Gérald Savoie a eu le mandat d'examiner précisément comment les décisions en matière de soins de santé touchant les francophones pouvaient être prises par des francophones, y compris la question de la gouvernance.

Nous savons qu'après neuf mois de délibérations, le comité de travail sur les services de soins de santé en français a déposé son rapport final en octobre, mais que la communauté franco-ontarienne ne l'a pas encore vu parce qu'il n'a pas été rendu public par le ministère. Nous attendons sa publication avec impatience.

Cependant, la position de la communauté franco-ontarienne sur la question de la gouvernance est claire. Il n'y a aucune manière d'arrêter la tendance à la détérioration des services de soins de santé en français si les Franco-Ontariens ne jouent pas un rôle central dans les décisions touchant ces services.

C'est un principe qui a été énoncé et répété dans plusieurs jugements de la Cour suprême du Canada. Voici ce que la cour disait dans le jugement Mahé en 1990 :

« ... les minorités linguistiques ne peuvent pas être toujours certaines que la majorité tiendra compte de

toutes leurs préoccupations linguistiques et culturelles. Cette carence n'est pas nécessairement intentionnelle: on ne peut attendre de la majorité qu'elle comprenne et évalue les diverses façons dont les méthodes d'instruction peuvent influencer sur la langue et la culture de la minorité. Commentant les différents revers subis par la minorité francophone de l'Ontario, la cour d'appel de cette province a souligné que 'ces événements ont été rendus possibles par l'absence de participation valable à la gestion et au contrôle des conseils scolaires locaux par la minorité francophone'. »

Cette citation porte sur l'éducation, mais le même principe s'applique aux soins de santé.

La majorité, et ce n'est pas de sa faute, est incapable de prendre les meilleures décisions pour la minorité. D'une certaine façon, il s'agit de l'ordre naturel des choses. Les membres de la majorité ne se réveillent pas chaque matin en se demandant ce qu'ils peuvent faire pour la minorité, tandis que les Franco-Ontariens se réveillent chaque matin en se demandant ce qu'ils devront faire pour survivre comme francophones.

Nous ne devrions pas avoir peur d'accorder aux Franco-Ontariens les moyens de prendre des décisions en matière de services de soins de santé pour la communauté franco-ontarienne.

Je ne suis pas venue ici pour vous parler au nom de l'Hôpital Montfort ou à son sujet, mais Montfort demeure un brillant exemple de la manière dont un important établissement de soins de santé francophone, dont la langue de travail est le français et la gouvernance francophone, fournit des services dans les deux langues officielles 24 heures par jour, sept jours par semaine, à titre de partenaire à part entière dans le système de soins de santé à Ottawa et en Ontario. C'est un hôpital très efficient qui fournit d'excellents soins de santé personnalisés.

Montfort est un partenaire à part entière parce que les rôles de chaque établissement dans notre région sont clairs. Peut-être qu'il a fallu cinq ans de chaos pour s'y rendre, mais c'est fait, et plus nous avançons avec des rôles bien établis, plus il y a de gens dans le système qui sont convaincus que les choses fonctionnent mieux qu'avant.

Vous devez comprendre que nous ne demandons pas un système de soins de santé en français séparé. Tous les services de soins de santé doivent être élaborés en les intégrant dans l'ensemble du système, et il doit exister une coopération et un échange d'information constants entre la majorité et la minorité en soins de santé.

Nous devons féliciter le ministre de la Santé et des Soins de longue durée d'avoir nommé quatre francophones au réseau local d'intégration des services de santé Champlain. C'est même plus que ce qu'il avait promis. Mais il y a 13 autres réseaux locaux, et il y a des francophones dans toutes ces régions. Plusieurs d'entre eux n'ont absolument aucun autre accès à des services de soins de santé. En fait, des études ont montré qu'une proportion ahurissante de Franco-Ontariens, 74 %, a peu ou aucun accès à des services de soins de santé en français. Seulement 12 % d'entre eux déclare avoir un

accès en tout temps à des services hospitaliers en français, et peu importe le nombre de francophones qui siègent présentement au réseau Champlain ou aux autres réseaux d'intégration, les gouvernements changent et les ministres changent.

Peu importe les directives du ministre, s'il n'y a pas une volonté au niveau local de tenter activement de fournir des services de santé adéquats en français, il n'y en aura pas. Nous avons entendu toutes les excuses pour tenter de justifier pourquoi certains fournisseurs sont incapables d'offrir des services de soins de santé en français. Aucune ne tient debout. Les mêmes excuses seront utilisées pour expliquer pourquoi les mêmes fournisseurs ne peuvent pas respecter les politiques du gouvernement. La communauté franco-ontarienne a les connaissances et le savoir-faire pour ne pas avoir à s'excuser.

Pour la première fois de notre histoire, le ministère de la Santé a consulté les Franco-Ontariens sérieusement en tant que groupe pour réaliser une importante initiative gouvernementale. Ce dialogue doit continuer afin que, dans une période de temps raisonnable, nous puissions avoir un système de soins de santé où les décisions touchant les francophones sont prises par les représentants de la communauté franco-ontarienne. Si nous ne le faisons pas dans le cadre de cette loi, il faut le faire spécifiquement et précisément dans les règlements.

Merci. M. Bernard Grandmaître, ancien ministre des Affaires municipales et ancien ministre délégué aux Affaires francophones, prendra maintenant la parole.

M. Bernard Grandmaître: Monsieur le Président, membres du comité, le préambule du projet de loi 36 déclare : « La population de l'Ontario et son gouvernement croient que le système de santé devrait être guidé par un engagement à l'égard de l'équité et un respect de la diversité des collectivités lorsqu'il dessert la population de l'Ontario et respecte les exigences de la Loi sur les services en français, lorsqu'il dessert les collectivités francophones. » Ça, monsieur le Président, c'est une première. Finalement, un ministre qui reconnaît pleinement l'importance de la Loi sur les services en français. De mémoire d'homme, aucune autre loi n'a jamais énoncé ce qui est une obligation légale importante pour le gouvernement de l'Ontario dans son préambule ou ailleurs dans le texte. Personne ne devrait faire l'erreur de penser que cette mention n'a pas force de loi parce qu'elle apparaît seulement dans le préambule. En fait, c'est précisément le sujet aujourd'hui de mon intervention en ce qui a trait à la Loi sur les services en français.

Vous savez peut-être que j'ai eu l'honneur de déposer ce projet de loi à l'Assemblée législative en 1986, à titre de ministre des Affaires francophones. J'ai été encore plus heureux d'être témoin d'un vote unanime des membres des trois partis de la législature et d'y participer pour approuver la Loi sur les services en français en troisième lecture. Une question qui aurait pu nous diviser profondément et diviser les citoyens de l'Ontario a fini par nous unir parce que c'était la bonne chose à faire au nom de la justice et des valeurs sur lesquelles est fondé le

Canada. Nous avons cru que c'était le début d'une nouvelle ère dans les relations entre la minorité et la majorité.

Le véritable changement prend du temps, et 16 ans se sont écoulés avant que la Loi sur les services en français prenne tout son sens, avec tout ce que cela implique, lors du jugement de la Cour d'appel de l'Ontario dans le cas Montfort en 2001. La cour, avec l'assentiment des avocats du procureur général, a déclaré que la Loi sur les services en français était une loi quasi-constitutionnelle. Cela signifie qu'elle passe avant toute autre loi, mais ce n'est pas tout.

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Le jugement Montfort est le premier en Ontario où les droits linguistiques, y compris la Loi sur les services en français, étaient interprétés d'une manière généreuse plutôt que restrictive—restrictive parce que la Cour suprême du Canada, dans le jugement Beaulac de 1999, a changé ses directives en matière d'interprétation des droits linguistiques.

Voici ce que la Cour d'appel de l'Ontario a déclaré dans la décision Montfort, et je cite :

« À une certaine époque, la Cour suprême du Canada interprétait les droits linguistiques dans une optique restrictive... Il est maintenant évident, toutefois, que cette approche étroite et restrictive a été abandonnée et que les droits linguistiques doivent être traités comme des droits fondamentaux de la personne et interprétés libéralement par les tribunaux. »

I'll speed it up.

En faire le moins possible—non, je ne peux pas me hâter, monsieur le Président, parce que ça joint.

« Au cours des 20 dernières années, ce n'est certainement pas la manière dont le ministère de la Santé et des Soins de longue durée a interprété les obligations découlant de la Loi sur les services en français. Il aurait pu être généreux et proactif dans la prestation de services de santé à la communauté franco-ontarienne sans l'intervention des tribunaux. Mais le ministère a choisi une attitude minimaliste, pour ne pas dire réductionniste. »

Mais la communauté franco-ontarienne a maintenant une raison d'avoir espoir. Nous voyons un gouvernement et un ministre qui semblent avoir décidé de changer radicalement la manière dont le ministère de la Santé et des Soins de longue durée perçoit la Loi sur les services en français. Ce gouvernement et ce ministre agissent avec fermeté en vue d'élaborer des services de soins de santé adéquats et insistent sur l'importance de rendre des comptes partout en province.

Cette loi doit être claire dans les intentions de promouvoir et de protéger activement les services de santé en français. Vous voudrez peut-être examiner des amendements qui pourraient atteindre cet objectif. Les règlements aussi doivent être clairs sur cette question.

Maintenant, monsieur le Président, pour hâter le processus, je vais céder la parole à M^{me} Lalonde, qui est bien connue dans la cause de Montfort.

The Chair: Merci pour votre présentation, en particulier pour vos collègues Monsieur Morin et Monsieur

Grandmaître. We thank you for making the presentation. There is about 30 seconds each that we will allow for questions or comments. Can I start with Mr. Arnott, please.

Mr. Grandmaître: Mr. Chair, instead of questions, we prefer that Mrs. Lalonde address the committee.

The Chair: For a minute and a half? Okay. Go ahead, Madame.

Mrs. Gisèle Lalonde: Can I give you at least one message? Ontario can certainly do better. Ontario must do better. The current LHIN makeup and framework is very troubling, because all it tells us is that we are going to get more of the same, which means, in time, our disappearance. If you look at the document we presented to you and if you read it, you will see that what I say is very, very true. We refuse to live as second-class citizens, unable to get adequate health care services in the country we founded.

As Mr. Morin said, we are not second-class citizens. We have been here since the very beginning, and we should be respected, at least in the report—we are not even there—when you are speaking about other founding nations. We are one of the founding nations. The last thing we want is to have to resort to the courts once again. We don't want to go to court. We had to go to court for education; we had to go to court to keep our hospital open. We don't want to go to court for these LHINs. This is the message I want to give to the actual government. Thank you.

The Chair: Thank you very much again for the presentations.

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION,
HOSPITAL PROFESSIONALS DIVISION

The Chair: The next presentation is from the Ontario Public Service Employees Union, hospital professionals division, Brendan Kilcline. Sir, you can start any time you are ready. There is a total of 15 minutes.

Mr. Brendan Kilcline: Thank you. Good morning. My name is Brendan Kilcline. I work at the Kingston General Hospital as a laboratory assistant. I'm very proud of the work that I do. I'm also with OPSEU. I'm very proud of my union. I'm on the hospital professionals division executive.

I'd like to make an initial remark. It's not that we are against the stated aims of having truly locally accountable, integrated, networked health systems; it's just that we don't think this bill achieves that particularly well. In fact, we have grave concerns that it actually might be counterproductive to those aims. I'd like to have a few comments, if I might, on the structure of the bill, the issue of labour stability and efficiency.

First, I'd like to highlight who we are and what we do. We represent an incredibly diverse group of highly trained hospital professional practitioners in diagnostic, therapeutic and support services. These are essential to the positive outcome of any medical intervention.

There's a lot more to a successful treatment outcome than the interventions of just our valued colleagues, physicians and nurses, but ours is a continuing struggle, as it were, to raise awareness within the public and within our members of government as to the nature and value of the services we provide. We perform the backbone of recovery in a patient-centred, interdisciplinary approach to treatment. This is the best and most cost-effective approach to patient care.

Unfortunately, this is the approach that would be dismantled if we end up going down the road of boutique medical clinics, of moving services out of hospitals inappropriately, and of increasing centralization or so-called rationalization of delivery, those models, and we feel that they are predictable consequences of this bill as it stands.

We've heard a number of things about the government's and Minister Smitherman's good intentions. We've even heard remarks that unions tend to be alarmist. Despite these good intentions, the bill, as it stands, sets up a framework that promotes the outcomes that we fear. It's somewhat like if I park a heavy truck on a hill without brakes. It may not be my intention to let the thing careen out of control down the hill, but the legislative framework—i.e., the laws of gravity—takes precedence, and that is the unintended consequence. So we have concerns about this bill overall.

I particularly want to talk about labour instability. It seems to us that the bill, as it stands, enshrines instability in the labour pool. Its structural, never-ending reform, rationalization, amalgamations, mergers are hardwired into the act, or the bill, as it is now. There's an indisputable fact that employment stability ensures the best patient care. We have had experience with home care which has been particularly disastrous, in our opinion, in the Kingston area. The experience of the workers and the patients in that kind of purchaser-provider split competitive bidding environment has just been awful. Elinor Caplan touches on just those things in her report. Again, despite what we're told about intentions, we believe that the structure of the bill itself leads to a certain inevitability about going down that road. It's not good for the workers and it's not good for the patients, and it doesn't get any more local than that. The front-line caregiver and the patient are as local as it gets, and we feel that this bill pays pretty much an afterthought to that relationship.

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We have considerable experience already with restructuring. We've had the Mike Harris Sinclair commission restructuring, so we're quite well aware about what happens in restructuring and its problems. We are actually still recovering from that. One of the effects of those restructuring exercises is that when people get moved around, they don't necessarily find themselves in employment positions where the skills and experience they spent many years obtaining are deployed as they were previously. Staff end up getting moved out of their particular areas of expertise and get placed back on the learning curve.

Remember, we have an extremely diverse group of professionals. The learning curve is long and steep, and it just doesn't make sense to take people at the height of their expertise and reassign them in areas where they might have to reacquaint themselves with other specialties within their profession. They're all professional, they're all capable of doing that, they're all licensed to do that, but the truth is, the degree of specialization in our professions is extremely high. We feel that it's folly to institutionalize that kind of constant moving and restructuring and relocation of services. At least with the Sinclair restructuring, there was an end point, and we are on the way to recovering from that. Workers are tired of endless amalgamations, mergers and privatization. They want to stay focused on their job, which is looking after the public.

If we look at the demographics in our professions—I take this information, actually, from the ministry's educational website; it's got lots of good information on there—our professions are 80% female. A very high percentage are approaching retirement age, and we have relatively few younger workers in the system. Women are still primary caregivers in the home to children and elderly relatives. They are much more likely than men to put their careers on hold to address their responsibilities, and they do not have the degree of labour mobility that perhaps men have, as a whole. What this bill does, we feel, is institutionalize the moving of services from one place to another.

Many will not transfer with service. They're close to retirement, so they will choose to change careers or retire, and that will be a huge loss of skills. Many will stay in their homes and commute greater distances. This presents a number of problems, one of which we experienced during the ice storm. Because our workforce generally tends to locate close to the place of work, most of our workforce was able to come in to work despite the ice storm or other similar disasters. When you start moving people around on a fairly frequent basis and relocate services through the district, workers invariably end up commuting longer distances, and fewer of them would be able to respond in that kind of circumstance.

It gives rise to great recruitment and retention issues. How can we attract young women to our professions when they have this degree of instability in their working lives? There are already severe shortages in our professions.

The other thing is, as service alignments are constantly being reviewed—the location of the service, where the service will be, in a very large geographic area—self-fulfilling prophecies occur. When relocation of a service is contemplated, people don't wait. They start seeking positions elsewhere. These are highly trained professionals. When they get another position elsewhere, because they don't want to wait for an impending change or they feel their job is insecure, programs actually fail because the staff move. They get appointments elsewhere, possibly in the United States, and the program vanishes because the staff aren't there to deliver it.

There has to be a sensible and fair human resources strategy as a prerequisite to this and not as an afterthought. The number one priority should be labour stability. We have to negotiate a fair human resources adjustment plan with labour before attempting anything else, not as an afterthought. We don't deserve less. We demand no less.

On efficiency: Our hospitals are the most efficient in Canada. Our hospital public labs are the most efficient in Canada; in Kingston, the most efficient on the continent. What we are very concerned about is that this bill will cause hyperconcentration of services. This is an all-your-eggs-in-one-basket approach. It is a dangerous approach. There is a plateau curve on efficiency. What happens is that your increase in efficiency is very minor but your risks increase. The services are farther away from the point of delivery, from the communities. Disasters do happen. Structures burn down, diseases sweep through workforces. You end up with a hyperconcentrated delivery model, and there is no reserve capacity.

The Chair: One minute left, sir.

Mr. Kilcline: Okay. We're very concerned about that. The structure of this legislation guides delivery in that way. It's dangerous to rush into poorly-thought-out structures. The bill does not address the major cost escalators but attempts to squeeze the last drop out of already extremely efficient sectors, at great risk to the capacity of the system. The public and workers will not stand by and watch the province's most cherished program be mismanaged by ministers who seek to act first, plan later and leave the public and the front-line workers to pick up the broken bits.

The Chair: Thanks very much. There are 30 seconds if somebody wants to ask a question. Madame Martel, any questions?

Ms. Martel: Thanks.

The Chair: Do you have one?

Ms. Martel: No. I said, "Thanks."

The Chair: Okay, thanks. That's fine. Thank you for your presentation.

PERLEY AND RIDEAU VETERANS' HEALTH CENTRE

The Chair: The next presentation is from the Perley and Rideau Veterans' Health Centre, Greg Fougère and Peter Strum. Welcome. Good morning to both of you gentlemen. You can start whenever you're ready.

Mr. Peter Strum: Good morning. We appreciate the opportunity of presenting our thoughts on Bill 36. My name is Peter Strum, and I am a member of the board of directors at the Perley and Rideau Veterans' Health Centre. I chair a special task force that deals with the LHIN legislation. With me today is our chief executive officer of the health centre, Mr. Greg Fougère.

I'm going to say a few words just to position who we are and from what perspective we're making our comments. In particular, I think you'll see that we demonstrate a leadership role in long-term care in this part of

the province. You will hear from the remarks of Mr. Fougère that we are very supportive of your legislation. We think it has many fine attributes. There are a few minor points that we would suggest you look at, and there is one major point that we think actually taints what is otherwise a good piece of legislation.

The Perley and Rideau Veterans' Health Centre is a non-profit long-term-care facility operated under the Charitable Institutions Act. We have a resident population of 450. Our operating budget is supported two thirds by the Ontario government and the other one third from Veterans Affairs Canada. About half—that is to say, 250 beds—are for the veterans. This being the Year of the Veteran, it's perhaps appropriate that we speak to that.

You will hear from my remarks that we have a leadership role at both the local and the provincial levels in the area of health care for our seniors. In particular, I draw to your attention that Mr. Fougère, who's with us today, has served as chair of the Ontario Association of Non-Profit Homes and Services for Seniors for over three years.

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If you were to come to our facility, you would find that the Health Services Restructuring Commission has its offices in our building, and our staff are often at various tables dealing with issues related to the Champlain Dementia Care Network.

We have already had the chair of the LHIN speak with us, as well as the CEO. We very much appreciate their efforts to meet with us and discuss the issues. We actually would commend the government, and we think we're very lucky, in the selection of those two gentlemen because of the vast experience they bring to the issues in this community and their knowledge of hospital administration, public health, long-term care and community-based health care. In this LHIN, we think we're off to a good start.

Our board has been adamant that it intends to work with the LHIN in advancing the goals and objectives as stated by the Minister of Health. We believe in, and we think we can show by example, how non-profit, long-term-care homes can step out of the traditional box to serve a broader range of health care needs for our seniors. For example, at our facility you would find that we house the Alzheimer Society of Ottawa to provide instant access, support and information for families and staff of residents in our home as well as for the broader community. Veterans Affairs has an office with us. The Victorian Order of Nurses manages our dementia respite day program for 64 community-based clinics each and every week of the year.

We have six clinics at our facility, again showing our leadership and our thinking about the kind of care that has to be developed for long-term care. Those kinds of clinics include audiology, chiropody, dental services, occupational therapy, a pharmacy and physiotherapy.

Our facility was one of only two homes in Ontario to pilot a 13-bed convalescent care program, in co-operation

with the ministry, the Ottawa Community Care Access Centre and local hospitals. The purpose? To free up badly needed spaces in our hospitals, to free up those acute care beds. We think it's the kind of integration that has to be looked at. That pilot which we worked on is now being rolled out across the province.

Our latest project is an endeavour between the Victorian Order of Nurses, the Alzheimer Society and our facility, the Perley Rideau, to build and operate a first-of-its-kind respite bungalow in this area. A guest house or a home away from home is located on our grounds and will offer respite to 12 men and women in early to mid-stages of Alzheimer's disease and other dementias. It really offers care, and extended care, if you like, to help caregivers deal with that kind of a health problem.

That's the kind of facility we have. That's our organization and our perspective in this community. I think you can understand, therefore, that we have a huge vested interest in what the LHIN is doing.

As I said earlier, Mr. Fougère will now speak to the fact that we have a couple of suggestions, but there is one area in particular that we are concerned about.

Mr. Greg Fougère: The Perley Rideau supports the enactment of Bill 36 to provide a legislative framework for local health integration networks. While supporting the objects of LHINs in part II and section 5, and being ready and eager to assist in their achievement, we caution that achieving efficient health services, as promoted in clauses 5(a) and (j), should never be exclusively defined as promoting the lowest-cost service. Often, especially in the non-profit sector, health services may be offered to people with special needs who may not receive care from some health service providers due to their higher needs and therefore higher cost.

We support health service providers entering into agreements to achieve performance standards, in clause 5(l), and service accountability agreements, in part IV, section 20. In fact, long-term-care homes already enter into service agreements with the Ministry of Health and Long-Term Care, and must annually comply with standards set out in the Charitable Institutions Act.

We're also very encouraged by part III, related to planning and community engagement. We will provide input to help shape the provincial strategic plan and will actively participate in the development of the local integrated health service plan for the Champlain LHIN.

However, there are two areas of serious concern that we would like to bring to the standing committee's attention and request that further work be done on before completion of Bill 36 prior to moving to the next legislative step. These two areas of concern relate to the limited and discriminatory scope of the integration powers of the minister under section 28 and sections throughout the bill that deal with matters of compensation and liability and the lack of protection of boards of directors of health service providers.

Section 28 is our more serious concern. This section would give the Minister of Health and Long-Term Care powers to force mergers and shut down health service providers—but only in the not-for-profit sector. It is not

in the public interest to have discriminatory and prejudicial legislation which allows the minister to only issue integration orders against not-for-profit organizations. This is particularly worrisome in the long-term-care home and community services sector, where many for-profit corporations receive public funds to provide health services. For example, more than 50% of long-term-care beds in Ontario are operated by for-profit corporations who receive public funds and are considered health service providers under Bill 36.

We do not understand and consider it bad public policy, and certainly not in the public interest, to exclude the for-profit sector from the powers of the minister to cease operations, amalgamate or transfer operations. This section of the legislation could have the unintended consequence of increasing private, for-profit care in the long-term-care sector. This would certainly be contrary to the McGuinty's government's vocal opposition to private, for-profit health care. We fully support our provincial association, the Ontario Association of Non-Profit Homes and Services for Seniors, in calling for section 28 to be either removed from the bill or revised to apply to all health services.

The second area of concern relates to the area of liability and compensation and the lack of protection of boards of directors of health service providers. Local health integration networks were introduced by the McGuinty government as a made-in-Ontario solution to a regionalized and decentralized approach to health care, a laudable initiative which we fully support. As a made-in-Ontario model of locally planned and funded health care, different from other provinces, the government has kept the boards of directors of health service providers intact. Bill 36 indemnifies and saves harmless the minister, the LHIN boards and the executives, but does not do the same for the boards, directors and executives of health service providers, and we feel that this issue needs to be dealt with before the bill moves forward.

In closing, thank you for this opportunity.

The Chair: Thank you very much for your presentations. There's no time for questioning, but thank you very much.

ASSOCIATION OF FUNDRAISING PROFESSIONALS

The Chair: The next presentation is from the Association of Fundraising Professionals, Tami Mallette.

Mr. Boyd McBride: Good morning. My name is Boyd McBride and not Tami Mallette. I'm sorry.

The Chair: Sorry. That's not the one I have here. But welcome and good morning.

Mr. McBride: Thank you for having me here as a representative of the Association of Fundraising Professionals. I serve as the national director of SOS Children's Villages, an international children's charity, but I'm here today testifying as chair of the government relations committee of the Association of Fundraising Professionals.

I'm here to address just one issue covered by the proposed act: the power it gives the minister and local health integration networks to transfer charitable property as part of changes to the system of health care delivery. But let me back up for just a moment and explain why AFP has an interest in this.

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We're a 27,000-member association with 175 chapters around the world and a good representation here in Ontario, members who raise funds for charitable organizations, including many health care institutions in the province. We have over 2,700 members across Canada and over 1,000 members in Toronto alone. I just cite this as background to emphasize that AFP brings expertise and background on issues relating to charitable donations, stewardship and the voluntary sector to this discussion and to many others we've had with government at various levels over the years.

Much of our energy and effort as an association is spent educating and training members in ethical fundraising practices and working with federal and provincial governments, regulators, to improve the regulations and the regulatory framework which supports and sustains the philanthropic process in Canada. We have supported many initiatives on the part of federal and provincial governments to enhance appropriate regulation of charities and fundraising, and in each case we try to help regulators understand the balance between their need to regulate and the need of the sector to be able to raise funds effectively for critical programs like health care programs, which I think you've heard a lot about this morning.

We would like to register our concern that the proposed power to transfer charitable property in this legislation is unprecedented and, we feel, may be unnecessary and could in fact be detrimental to all the parties involved. Bill 36 includes a measure which would enable the minister and local health care integration networks to order a health service provider—including hospitals, psychiatric facilities, seniors or nursing homes, and such—to transfer charitable property to another health service provider. We have never seen a regulatory entity given this type of power over charitable property, and it's unclear to us that what we feel is kind of a drastic step is necessary.

The proposed provision covers decisions which are, in a sense, already generally taken by the courts. Under the cy-près doctrine, the courts may alter the terms of a charitable trust where the maintenance of those terms is no longer practicable. So if somebody leaves an endowment to an organization like the one that just testified and that organization goes away, the courts typically will intervene to find a way to transfer those resources to another organization doing the kind of work that the donor originally intended to support.

In exercising this kind of jurisdiction, the courts attempt to preserve the overall intent behind the charitable donation in circumstances where it's no longer possible for the trustee—the charity—to comply with the

trust's exact terms. We believe that the courts are in fact better placed than the LHINs or the minister to make decisions regarding transfer of charitable property like this. The courts are impartial, transparent, have the expertise and experience in making such decisions, and provide a forum for all the interested parties, including donors and health service providers, to provide input into how or where the charitable property should be transferred. So donors can take some comfort in the fact that the courts will preserve, as much as possible, the intent behind their charitable donations.

We're actually a bit curious—and this is a dialogue that we're quite happy to continue participating in—as to how the minister or a LHIN could compel a transfer when most gifts are a legally binding contract between the donor and the recipient health service provider. We're also troubled by the fact that donors and health service providers have no voice in the proposed process and feel that if the measures advance as described in the legislation, we could find ourselves in a situation where there's a loss of confidence among donors in their ability to make a gift to a health care institution and know that it will in fact do what they want it to do.

It's our experience that people generally donate charitable property to specific groups for very specific purposes. We find that donors take the time and effort to make those kinds of informed choices when they bestow their gifts. To most donors, one non-profit doesn't necessarily equal another. They're making choices as they make the gift. There may be all kinds of good reasons why a donor chooses to support one particular health service provider over another. We just believe that donors' gifts are not interchangeable, and they're very often quite personal to the donor.

A couple more comments and then, if there's time, I'm happy to try to field questions. We understand that if donors feel they're losing their voice over the use of their gifts to health service providers, it's possible that they'll donate their property to organizations completely unrelated to health care where they can be confident that their gifts to the library or to a community service organization will be retained in that institution and used in the intended way. I don't think anyone at this table wants us to see donations to health care institutions diverted because there's a loss of confidence in the ability of those funds to stay with the institution. We think it's possible that this provision will have a chilling affect on charitable giving and weaken the health service providers that rely on donations of charitable property, particularly legacy gifts.

We're wondering if a compromise could be fashioned that would allow the ministry to meet its goal of creating a better-integrated health system without undermining the best interests of the donors and the health service providers. We just feel that the Ontario government should be doing everything it can in this to enhance rather than impede the role of the voluntary sector in delivery of these critical services.

Based on this kind of reasoning, AFP urges the committee to remove the problematic provision that would

enable the minister or the local health integration network to order a health service provider to transfer charitable property to another health service provider. With more information and background regarding the rationale for the provision, we at AFP would be willing to bring some of our resources to the committee to perhaps fashion a compromise provision that would achieve a similar goal for the ministry without undermining donors and their gifts to health service providers.

Perhaps on that point, I'll just say that we look forward to working with the committee, if that's your wish. Thank you for time.

The Chair: We have 30 seconds each. Mr. Wilson can start with some questions.

Mr. Wilson: You've raise an excellent point, sir, in terms of section 30. I don't know what it's in there for. The only example we have that research gave was that if they close a hospital and the foundation had held money for the construction of a surgical wing, then the money has to go to whoever's taking over the amalgamated entity, I guess; something like that.

The fact of the matter is, these are 14 health service restructuring commissions that are being set up. They'll have, between themselves and the minister all the power they need to close whatever they want. I think this is to keep those transfers of property out of the courts, to try and simplify it. You raised the point that maybe it won't work that way.

Mr. McBride: I'm suspicious that if a donor's intent is somehow compromised, it will end up in the courts in any event. We just feel that we don't want to have donors lose confidence in their ability to have their views, their wishes, followed as much as possible, and that's generally a decision of the courts.

The Chair: Madame Martel.

Ms. Martel: Thank you for being here this morning. I take it you didn't see this in the legislation before it was introduced; I don't think you were consulted about it. Since you have seen it, since the legislation has been introduced, have you made an effort to talk to ministry folks about this, and where have you gotten with that?

Mr. McBride: To my knowledge, we have not. But I will check on that and get back to you.

Ms. Martel: So from the committee's perspective, this is the first time it's been raised by the association in a forum, either public or otherwise, to bring to the attention of the ministry your concerns.

Mr. McBride: I believe that's correct.

Ms. Martel: So we'll wait to see if the government's going to do that.

The Chair: The final word to the local MPP, Mr. Patten—before lunch, that is.

Mr. Patten: Hi, Boyd. How are you? Good to see you.

Mr. McBride: Good to see you, sir.

Mr. Patten: By the way, I think you raised an excellent point. I would ask you if you could put that down in letter form for us.

To respond to you, I think the intent was that the government isn't going to pay twice to purchase property

that was already deemed to be serving the general public and that kind of thing. However, as you know, I worked in the voluntary sector for many years and I have great sensitivity to the growing government impact on the voluntary sector, which can sometimes have negative effects and unintended consequences. This may be one of them. I'm thinking there are some fuzzy areas in here, and you raise a good point.

I understand the intent of the legislation, and it says what they would not do and would not force organizations to do etc. But it identifies only health care providers, and some organizations are multifaceted. I'm thinking of the YMCA, which has health services, counselling services, recreational services, development services and all kinds of different things. It could be fuzzy in that particular area.

But if I might ask you if you could put it in a letter form and send it to us. That would be very helpful.

Mr. McBride: To the committee?

Mr. Patten: Yes.

Mr. McBride: I'd be happy to do that. We've prepared a four- or five-page brief, but if you'd prefer it in a letter format—

Mr. Patten: If the brief is there—I haven't seen it.

Mr. McBride: I'm sorry. It was just delivered to me yesterday, and I'm happy to make copies and have it delivered to you today.

The Chair: So we'll all get a copy. Thanks very much. Thank you for your presentation.

We will break for an hour for lunch, and we'll be back here at 1 o'clock.

The committee recessed from 1202 to 1300.

ONTARIO NURSES' ASSOCIATION, LOCAL 84

The Chair: Bienvenue. It is 1 o'clock. We thank you for coming. You are from the Ontario Nurses' Association, Local 84, Ottawa?

Ms. Anne Clark: I am.

The Chair: You may start your presentation. There is 15 minutes total time.

Ms. Clark: Good afternoon. My name is Anne Clark. I'm a vice-president of the Ontario Nurses' Association. With me today are Jan Davidson, ONA's project manager in our response to LHINs, and Marc-André Pelletier, one of our servicing and team managers.

Currently, I am a clinical resource nurse in my hospital who has been nursing full-time since 1980 in Nepean. Due to the last round of restructuring in the mid-1990s, I had to add urology to my skills, as all specialty surgery was consolidated and beds were closed. It looks like nurses will be forced to go through it yet again.

Yes, Minister, change is hard. Nurses have already suffered through many rounds of restructuring. It may be new to this minister, but not to nurses.

Let me start by telling you that ONA has 10,000 members in the Ottawa area, what we refer to as region 2 in our structure, and the surrounding three local health

integration networks, or LHINs. We have registered nurses and allied health professionals working in all sectors currently included under Bill 36—hospitals, community care access centres and long-term-care facilities—and in public health services, which are excluded from LHINs.

Nurses in the Ottawa region have had a number of experiences with restructuring in both the hospital sector and the home care sector. I want to tell you, however, that nurses are not prepared to be treated as poorly as they have been in the past. Our members in Cornwall, for example, report that they haven't heard anything yet as far as consultation with the public about LHINs. They also report that the community in Hawkesbury is expressing concern already about reduced access to services from clinics—for example, diabetic, haemodialysis and cardiac—if they are moved into the community out of the local hospital. Concerns are also being expressed over the impacts on patient care if non-clinical services, like housekeeping and dietary services, are centralized.

Today, I want to expand on issues in Bill 36 related to protecting the public interest and restricting privatization of health services as the delivery of services shifts: the failure to identify the public interest criteria on which funding and integration decisions will be made; the failure to protect medicare and to ensure adequate funding to maintain publicly funded health care as well as for the transition to the new model; the promotion of extra-billing and user fees by allowing for the transfer of services which are currently being publicly funded and delivered to delivery by for-profit providers; and contracting out of non-clinical services that are critical to patient care and to the health and safety of health care workers.

If we agree that the purpose of the bill should be to implement seamless health care for patients, then we fail to understand how this can be accomplished without a process for integration decisions to be weighed against criteria that define the public interest. It's our view that the public is entitled to know exactly what factors are being considered. Consequently, in our written submission we will be making a proposal that all funding and integration decisions should be exercised in a manner that is consistent with factors that would define the public interest.

Let's move now to how Bill 36 fails to protect medicare.

First of all, it's our view that Bill 36 fails to ensure that there will be adequate funding to maintain publicly funded health care as well as funding to ensure transition to the new model. Accordingly, we will be making a proposal that there be a legislative requirement for sufficient additional funding to achieve all the purposes of the act.

In this regard, the only provision that specifically addresses the minister's unfettered discretion around funding is the ambiguously drafted section 17. In section 17, "the minister shall consider whether to adjust the funding to take into account a portion of any savings from efficiencies ... that the network proposes to spend

on patient care.” Obviously, we will be making a proposal that any and all savings identified should be re-invested in patient care.

Because LHINs are being implemented before a provincial strategic plan has been released and because there are no details regarding the criteria or model for funding each LHIN, we are concerned that regional inequalities in health care services may develop between LHINs. We are also concerned about what will happen to services if, for example, there is a deficit in one of the LHINs or in one of the health service providers. This is currently the situation, for example, at the Peterborough Regional Health Centre. We will therefore make a proposal that funding cannot result in regional disparities between LHINs.

Our final proposal related to funding will be to propose an expansion of current programs to cover the increased travel in all LHINs that will certainly result from integration and consolidation of services.

Let me turn next to our concerns in Bill 36 related to the model for purchasing services. The minister said on Monday that he wants the committee to ask the question, “Where in the bill does it say that?”

Well, first of all, LHINs do not deliver health care services. LHINs appear to be set up much like the introduction of community care access centres—CCACs—in the home care sector in the case of home care delivery, where funding flows to the CCACs, which then purchase services through a competitive bidding model. Will this competitive bidding model from CCACs be expanded to LHINs for the purchase of acute, long-term and community care? We don’t know, but the structure for that to happen is certainly being put in place. The competitive bidding model may not be expressly stated in Bill 36, but neither is any other funding model. We do know that LHINs are being set up in the same fashion as CCACs: The purchaser and provider of services is split up.

If the competitive bidding model is introduced, we have grave concerns based on our experience in home care. In the home care sector, the competitive bidding model opened the door to the delivery of home care by for-profit companies and resulted in less care and a lack of continuity of care. The competitive bidding model has resulted in job loss for nurses when contracts are lost. In Kingston, for example, a for-profit company won a bid, and then once ONA negotiated a first contract, they simply closed up shop. Closing down nursing services because of lost contracts has occurred all across the province.

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Competitive bidding has meant nurses being forced to leave the home care sector because of lower terms and conditions of work in the new employer. It has also resulted in a lack of continuity of care for people receiving care in their homes. We are extremely concerned about the prospect of widespread turmoil for patients and health care staff if such a competitive funding model is introduced by LHINs.

Minister, there is a solution. Simply write it into the bill: no competitive bidding. We will propose a prohibi-

tion on the competitive bidding model for the purchase of services by LHINs.

We are also concerned about the potential for further privatization of health care services flowing from integration decisions. Of particular concern for nurses, despite the minister’s reassuring words, is that the only provision that proposes to address this is subsection 25(3). LHINs may not issue integration decisions that “permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise permitted by law.” What interpretation are we to give to this language? We believe it is ambiguous, inadequate and opens the door for private clinics to set up shop. Our view is that a much more explicit and enforceable statement is required to prevent further privatization of health services. Therefore, we will make a proposal to restrict any transfer that results in a requirement for an individual to pay for services previously publicly funded.

Also of concern in this regard is why the government has limited its powers in section 28 with respect to the minister ordering only not-for-profit health service providers to cease operating. This limitation appears to favour for-profit delivery of health care, and we believe it to be inconsistent with the principles set out in the Commitment to the Future of Medicare Act.

I’d like now to move on to our concerns related to contracting out of non-clinical services that we believe to be critical for patient care and for the health and safety of health care workers. In section 33, cabinet may, by regulation, order public hospitals to cease performing any non-clinical service and to integrate the service by transferring it to another “person or entity.” We are concerned that non-clinical services are separately targeted and being treated differently than all other health care services.

Our particular concern is the consequence of contracting out certain non-clinical services—for example, housekeeping and dietary—which are critical to patient care. Nurses are unable to provide quality care if we can’t rely on the quality of non-clinical services. In addition, these non-clinical services are essential to a healthy workplace and for protecting the health and safety of employees.

Furthermore, the contracting out of non-clinical services such as human resources runs contrary to the whole purpose of maintaining good employee-employer relationships. Contracting out this relationship will only serve to erode morale further and to increase retention and recruitment problems. All of this will be happening at the same time as the shortage of nurses and other health professionals is growing worse as a result of upcoming retirements.

Our intention is to ensure that health reform is done right and results in a genuinely integrated health system. Specifying criteria to define the public interest, restricting further privatization and maintaining a public delivery model are key success factors to ensure that health reform is done right.

Thank you very much.

The Chair: Thank you. There's about a minute and a half total left. I'll start with Ms. Martel, please—30 seconds.

Ms. Martel: Thank you for your participation here today. Thank you very much for talking about competitive bidding, because you're right: The minister said, "I don't see it anywhere in the bill, so therefore it is not to be." The way to resolve that is to place the amendment. I'd be happy to place yours or my own and see how the government responds. With that, I think we will very quickly find out where everybody stands on this issue.

I want, though, to talk to you about section 33—you read part of it into the record—because, as I read it, I think this is the section the minister will use for privatization. I think that's very clear. My other concern is that "non-clinical services" is not defined anywhere in the bill, so while we, amongst us, talk about housekeeping and human resources, the fact is that that's open to interpretation, and I'm not sure where that's going to take us.

What are you concerned about with respect to that particular section, where there's no definition of "non-clinical services," but it's also very clear that the minister, of his own volition, can order integrations under this section, ostensibly through a wide range of public hospitals?

Ms. Clark: It's very all-encompassing and there's very little groundwork, very few rules, very little detail. There need to be specific detail and rules in place.

The Chair: Thank you. Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Do you not feel that for the people of Ontario, when it comes to something like procurement—and I'll just take the example of an MRI machine—we would be able to get the best value for money by doing this in a large, regional way or in a provincial manner so we're able to get that at the lowest cost, and those precious health care dollars we're saving can then be used to serve our patients better?

Ms. Clark: We believe in a seamless health care system in which those things would be funded, but nowhere in LHINs does it say that's going to make that situation any better. That could be done now without this legislation.

Mr. Fonseca: But right now, things are through a hospital or through other organizations; this way, it could be provincially or it could be regionally, and it would allow us to get the best deal for the people of Ontario.

Ms. Jan Davidson: I'm just going to take about five minutes on this—no, I won't.

The Chair: Ten seconds.

Ms. Davidson: I know. It's one thing to purchase equipment on a bulk basis to get the best price—

Mr. Fonseca: I'm just asking if that was a good idea.

Ms. Davidson: —but our concern is that you may be trying to purchase the bulk staff at the best price too, and that just doesn't go with purchasing materials.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Thank you very much for your presentation. I'm glad to see you. We don't very often agree

on things, I suppose, but we certainly agree on much of this.

You mentioned some of the costs. I never really thought of it in terms of travel costs for your members. Any other costs that you think your members might have to incur as a result of this legislation?

Ms. Clark: It's not just our members; I'm talking about the general public. When somebody is enrolled and gets into the health care system, that patient's whole psychological being, the outcome for whatever the problem is, is entailed in his family. If you're in Hawkesbury and you're having to travel to somewhere else in this province, if your family's in Hawkesbury and you could be 200 miles away, that is interfering with quality patient care; it's splintering services. In our view, that's not an integrated system. Community matters.

The Chair: Thank you very much for your presentation.

KINGSTON HEALTH COALITION

The Chair: We'll have the next presentation, from the Kingston Health Coalition, Ross Sutherland. Please start whenever you're ready. There is 15 minutes total.

Mr. Ross Sutherland: Total? Thank you. I heard that. Will you tell me when 10 minutes is up so I can stop?

The Chair: At about a minute, I'll do that for you.

Mr. Sutherland: No, 10 minutes would be great. I'll appreciate the 10-minute time.

Anyway, thank you very much, committee, for allowing me to come and address some of our concerns about Bill 36, the Local Health Systems Integration Act.

Members of our coalition have voiced numerous concerns about different aspects of the legislation. We're worried about the effect of the purchaser-provider split model for developing services and the result this will have in shifting valuable health care dollars from patient care to administration, with no clear benefit. We question how the goal of integration can be met with the omission of key sectors from the LHINs' purview, specifically doctors, independent health facilities and commercial medical labs. The lack of value statements similar to those contained in the Canada Health Act and the omission of support for the non-profit character of the system have raised concerns that Bill 36 will not work to support our public health care system.

As important as each of these are, I know that others from Kingston are addressing them in detail. I would like to use this time to discuss the proposed governance of the LHINs and the impact of this centralizing structure on health care.

The preamble of Bill 36 indicates the intention of giving communities a key role in developing their health care needs and priorities and in making decisions about their local health systems. Accountability and transparency are identified as important. Section 5 talks about community engagement, and there are to be committees of health care providers and provider agencies but noticeably none for patients and the community at large.

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We would suggest that to meet these goals there needs to be the ability for open discussion and engaged dialogue in the community, which means we need equal knowledge between interested participants, accessible information, and the ability to express opinions without fear of consequences. Central to this is the ability of the LHINs to act as an independent voice for community interests, or, to put this in the negative, without communities having full information on cost alternatives—what works, what does not work—how can they participate in any meaningful dialogue or priority-setting or give considered input to decisions? Without formal community input channels that give the community a voice at the table, with an appropriate appeal process, what reason is there for the LHINs management to seriously consider concerns of the residents? Without some form of independence from the ministry, what ability is there for the LHINs to speak up for the community, instead of just becoming “Yes, Minister” organizations that cannot offer considered critical opinion without fear of losing their jobs, their salaries or violating the law if not co-operating with the ministry?

To understand the importance of these governance questions to a healthy health care system and to a functioning democracy—that is, one where there is some balance in the system and communities have rights where they can access the information they need for considered discussion and where they have the ability to speak up for their interests—we need only look at a relatively recent example in Ontario: the evolution of governance of the community care access centres.

The CCACs and home care have been a major focus of the work of our local coalition, and we feel there are many lessons from that experience with the CCACs that are germane to the current LHINs discussion. Like the LHINs, the CCACs were set up to coordinate community-level health care services. But unlike the LHINs, when they were initially constituted they were set up with locally responsible boards and CEOs who were hired by those boards. To be sure, they had to work within provincial guidelines and funding restraints, and many of the boards chose relatively restrictive engagements with their communities, but their line of responsibility ran to the community; it didn't run to the ministry. The first boards were appointed by the government; the subsequent boards were to be elected by members of the community. This was a fairly broad mandate, with most CCACs allowing most community members to participate in the process.

These structures led to some very interesting and important developments. CCAC boards around the province felt that they could stand up to the government when their waiting lists started to grow and funding restrictions meant a cutback in care, and they did this. They not only had an obligation, but they had the independence that allowed them to speak out for their communities. In Ottawa, the CCAC was able to point out the substantially increased costs of contracting out therapy services, and they had the numbers to make the argument well because

they were the agency involved in doing that. Sudbury was able to voice their concerns about the splintering of services if they contracted out their support workers. Many CCACs were willing to articulate their communities' needs in the face of provincial government restructuring.

This balance in power between the community and the province allowed for a creative tension where communities were able to speak up and they had the information they needed to make their case. It increased the chances of an open dialogue and solutions that worked for the community and provincial objectives. It sometimes was a bit messy, but that's politics; that's the basis of a functioning democracy and of meaningful local input. In the end, it did not stop the government from implementing province-wide policies that they felt were needed, but the format, as with municipal governments and school boards, created a balance between central power and community needs.

These other forms of local government are good comparisons. The LHINs will be administering budgets for an essential service that are as large as or larger than those in many school boards and municipalities. This is a format for local control that we're familiar with. And in terms of community priorities and fiscal responsibility, health care compares favourably to schools and municipalities. It seems reasonable to allow a similar level of community control.

In 2001, the previous government decided that it had had enough with communities speaking up for themselves and passed Bill 130, the Community Care Access Corporations Act, 2001. This bill changed the governance structure of CCACs to mirror the structure proposed for the LHINs. As with the reformed CCACs, the LHINs are to be an agent of the crown and act on behalf of the government. LHINs are to be governed by a board of directors appointed by cabinet and paid at a level determined by the cabinet. The government will determine who will be chair and vice-chair. Each board member continues at the pleasure of the cabinet and can be removed at any time.

This structural centralization of control is reinforced by a health care strategic plan that will be largely formulated outside of public debate; translated to local plans, once again developed largely outside of public debate; and then used as strict guidelines for determining the provision of health care. Communities not only lose control of the political process but are faced with a non-negotiable financial and policy straitjacket that limits the options of local providers and communities to respond with creative community-based solutions. The result of the 2001 changes to the CCAC governance was a complete silencing of the CCACs and the effective removal of the community from home care policy discussions. All the nice-sounding phrases about local control and bringing health care decisions closer to the community are essentially meaningless if they mask real power relations.

Mr. Patten: That was changed.

Mr. Sutherland: Well, I'm going to come to that, sir. I think it's a good point.

For the LHINs, the real lines of accountability run to the centre. They move power to the ministry and the minister's office rather than creating a healthy balance and the necessary tension to well-functioning democracies. As the CCAC history shows, this is not an academic concern but a real concern, with real consequences. It stopped information flow to the communities and effectively silenced voices that were concerned about local health care delivery.

The Kingston Health Coalition is concerned that if Bill 36 goes ahead as proposed, we will further undercut local control of health services just as Bill 130, the CCAC act, did to community care. We respect the importance of provincial guidelines and standards and our collective concern for prudent financial management, but we also strongly believe that communities, workers and patients need information, open channels of input and dialogue, and a local independent power centre to create a balance that allows communities to articulate and speak up for their health care needs.

We would encourage you to strongly reconsider the governance of the LHINs and allow for the direct election of the board of directors and the appointment of CEOs by those boards.

Am I at 10 minutes?

The Chair: Five.

Mr. Sutherland: That's perfect. I'm right on time.

This change would be a significant step in meeting the community control goals of the proposed legislation, as well as generally increasing the vitality of our democracy. Equally important, we'll be providing some public process for the development of the province's strategic health plan, which is the policy core of these initiatives.

We note that part VI of the proposed bill does redress some of the concerns with the CCAC governance, though it is unclear whether this is a return of the CCACs to the relatively open membership structure that was envisioned in 1966 or to the more closed model used by the hospitals. We would encourage you to make this clear in the legislation and implement the more open structure.

Once again, thank you for your time. I would be pleased to answer any questions.

The Chair: Thank you. There is a little more than one minute each. We'll start with Mr. Leal.

Mr. Jeff Leal (Peterborough): I'm from Peterborough. We share a lot of things with Kingston; we're an urban-rural mix. In my riding, I talk to seniors all the time. One of the problems for seniors, of course, is arthritic hips and knees. They want to be able to get access as quickly as possible; not months but weeks, for getting an artificial hip or knee. Do you not see it as a good thing that in these LHINs and in some hospitals within the LHIN we're able to bring together eight or nine or 10 orthopaedic surgeons to reduce wait times significantly for those seniors who are struggling with those bad hips and knees to get surgery and have them living a quality of life that they were used to many years ago?

Mr. Sutherland: If we had a community-controlled process that allowed us to integrate services for patients so they had some continuity of care and were allowed to

get health care accessibility as quickly as possible, that would be a very good thing. I'm quite concerned, though, that because of the centralization of the power in the LHINs, in fact what will happen is what happened with the CCACs, where what we've actually seen is a more fragmented system and a much more administration cost-heavy system, so we actually have fewer health care dollars going to patient care and more dollars going to administration. We've actually done a fair amount of work documenting that. We think that the administrative costs in the CCACs went to about 20% just because of the purchaser-provider split structure. We think, unfortunately, your goal can't be met with this legislation. That's my concern.

The Chair: Mr. Wilson?

Mr. Wilson: I think your chronology of the past is quite accurate. What do you do, though, when you have a rogue board? That was one of the reasons cabinet did move to rein in the CCACs, as you might put it. In my area they opened five offices. They advertised in the papers all the time. Snow removal was as important as the bath. There didn't seem to be any priority-setting, and yet we had provincial guidelines. We also had people who didn't like the government, just openly hated us, and they got themselves on these boards. So what do you do when things get out of control?

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Mr. Sutherland: I think the school boards provided a really interesting example of that.

Mr. Wilson: They hated us too.

Mr. Sutherland: Well, it was nothing personal, I'm sure.

The school boards, in fact, some of them—first off, they allowed communities to have some sort of a response to the government, which allowed this tension so they could negotiate solutions. When some of the school boards, in the end, decided to really buck the government trend, they were put under trusteeship. You can actually do that with individual ones, and whether you support that or not, it was a political decision at that point in time. But the fact of the existence of the school boards as something which had local connections allowed that tension, allowed that debate, so in fact we had a good debate. The government had the ability in that situation, as you know, to take care of a few school boards they weren't happy with, but in fact we had that. With the LHINs, we don't even have that. We just skip that whole tension. We've gone right to the centralization, and I think that's a problem.

The Chair: Thank you. Madame Martel.

Ms. Martel: Thank you for coming today. I want to focus on the governance model particularly. The government will say, "Well, yes, we recognized there was a problem in the CCACs, and that's why we're going to have open boards again and elections and the whole nine yards." My question is, if it's so good to do it for the CCACs, why not for the LHINs?

Mr. Sutherland: I think that's a good question. I do hope, in fact, that you go back—and I would like to see it

in the legislation—and put the CCACs back to the open model. Hospitals—I'm happy that they are controlled by local boards, but they are in fact quite undemocratic, really, and very difficult to get access to. The CCAC model was very interesting. It was only a short time that it was there and it was evolving, and I think it would be nice to go back and let that evolve more. I can't imagine why you would want to go back to the much more restrictive structure with the LHINs. It doesn't make any sense to me.

The Chair: Thank you very much for your presentation, sir.

RÉSEAU DES SERVICES DE SANTÉ EN FRANÇAIS DE L'EST DE L'ONTARIO

The Chair: The next presentation is from the Réseau des services de santé en français de l'Est de l'Ontario. Close enough? Thank you. I thought I'd better try a little. There are 15 minutes whenever you're ready.

M^{me} Nicole Robert: Monsieur le Président, committee members, bonjour. Bon après-midi. Mon nom est Nicole Robert. Je suis présidente du conseil d'administration du Réseau des services de santé en français de l'Est de l'Ontario.

Le réseau est formé de 61 établissements qui sont tenus d'offrir des services de santé en français à la population de la région de Champlain. Notre mandat est d'assurer l'accès à toute la gamme de services de santé aux quelque 250 000 francophones de l'est ontarien. Depuis huit ans, nous accomplissons ce mandat en collaboration avec nos partenaires par l'élaboration d'un plan régional des services de santé et le développement des services en français sur le territoire.

Depuis plus d'un an, nous suivons avec intérêt l'évolution des projets de transformation du système de santé du ministre de la Santé et des Soins de longue durée de la province.

Nous sommes d'avis que les principes d'imputabilité, de qualité et de soins centrés sur le patient s'appliquent aux services de santé en français et aux patients dont la langue maternelle est le français.

Nous avons bien accueilli l'idée d'un système qui tienne compte des besoins et de l'état de santé de la population francophone de la région.

Nous voyons également d'un bon oeil l'accent mis sur l'engagement des collectivités. Cela suppose une consultation et une participation de la communauté francophone aux décisions qui touchent les services en français.

Cependant, rien de cela n'est garanti dans le projet de loi 36 soumis à l'Assemblée législative.

La région compte plus de 40 % des 500 000 citoyens francophones de la province. De ce nombre, plus de 62 000 jeunes de moins de 24 ans auront recours au système de santé en français à un temps donné de leur vie. Et plus de 28 000 aînés et leur famille tentent d'avoir accès à des services de santé de qualité en français.

Par ailleurs, des milliers de professionnels de la santé francophones dans l'est ontarien cherchent à prodiguer les meilleurs soins possibles dans la langue du patient. Ils et elles le font par souci d'efficacité en sachant que la communication est à la base de tout soin de qualité.

Pour tous ces francophones, les services en français n'ont rien de folklorique. Au quotidien, la communauté francophone de l'est ontarien ne demande pas si elle a des droits aux services de santé en français. Elle pose plutôt la question : comment ces droits se traduisent-ils dans le domaine de la santé?

L'occasion est belle pour l'Ontario d'accepter un rôle de leadership à l'égard de la santé en français.

Vous me ramènerez à juste titre au préambule du projet de loi, qui spécifie que « la population de l'Ontario et son gouvernement ... respectent les exigences de la Loi sur les services en français lorsqu'il » —le système de santé—« dessert les collectivités francophones... » D'entrée de jeu, l'énoncé est encourageant pour notre communauté de langue officielle. Permettez-moi toutefois de témoigner de l'expérience du Réseau de l'Est quant à la Loi sur les services en français.

Une partie importante du mandat de notre réseau consiste à appuyer le développement des services de santé en français sur le territoire de Champlain. Selon le protocole d'entente avec le ministre, nous accompagnons les hôpitaux et les organismes communautaires en santé tout au long de l'élaboration de leur plan de désignation. Suite à une analyse des plans et d'une évaluation continue du niveau de prestation des services, le réseau est en mesure d'effectuer des recommandations au ministre.

Le processus de désignation est un moyen d'assurer la prestation d'une gamme donnée de services de santé en français par les organismes et établissements bénéficiant de paiements de transfert du ministère. Cette politique implique le respect de quatre critères qui sont mis en application à des degrés variables dans le système de santé actuel.

Au fil des ans, nous avons été témoins de progrès encourageants quant aux services de santé en français chez nos partenaires. Nous avons assisté à une amélioration de l'offre proactive de services de santé offerts à la population francophone. Dans tous les cas, la volonté de dirigeants déterminés a été le facteur clé de l'équation.

Tristement, nous avons aussi constaté des reculs importants dans l'accès aux services de santé par les francophones dans la région. Une partie du problème réside du côté des directives, normes et standards qui sont souvent non précis de la part du ministère. D'autre part, au-delà des ressources disponibles et affectées par les établissements et par le réseau, c'est le degré de priorité accordé aux services de santé en français qui est souvent en cause.

Ainsi, des changements au sein d'un conseil d'administration, la révision hâtive de politiques et procédures ou des modifications au chapitre des ressources humaines peuvent facilement compromettre la prestation des services de santé en français.

À l'heure actuelle, environ 30 établissements sont désignés et 40 sont identifiés pour fin de désignation dans

la région de Champlain. De par l'absence de mesures indicatives et incitatives, un trop faible pourcentage de ces établissements sont actifs, c'est-à-dire, travaillent activement à l'élaboration ou à l'amélioration de leur prestation des services de santé en français.

Au pire, une partie des services de santé en français sont aléatoires, et les fonds présentement affectés au maintien des services de santé en français ne sont pas toujours utilisés pour assurer l'offre et l'accès à ces services.

À moins d'imbriquer la responsabilisation quant aux services à même le règlement ou l'entente, les services de santé en français et l'établissement de tout continuum de soins ne reposent que sur des bases fragiles de bonne volonté, et ce, au détriment de la clientèle francophone. Pour l'heure, l'imputabilité réelle est loin d'être atteinte.

Pour qu'il y ait véritable reconnaissance de « l'apport du patrimoine culturel de la population francophone et ... sauvegarde pour les générations à venir », tel que stipulé dans le préambule de la Loi sur les services en français, nous avons besoin de beaucoup plus que de la bonne volonté en santé. À elle seule, la référence à la Loi sur les services en français du projet de loi 36 ne répond ni aux attentes du ministre Smitheman ni à celles de la communauté francophone en ce qui a trait à l'imputabilité et à la qualité des services de santé offerts en français à la population de l'Ontario.

Depuis huit ans, notre réseau travaille de concert avec ses partenaires à l'amélioration de l'accès aux services de santé en français. Notre intervention aujourd'hui va dans le même sens. Nous sommes ici pour contribuer à la planification, au développement et à l'évaluation des services de santé en français dans la région Champlain.

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En égard au projet de loi, nous soulevons donc ces questions en vue d'une meilleure imputabilité du système à l'endroit des services en français :

De quelle façon le ministère de la Santé et de Soins de longue durée et le RLISS engageront-ils la communauté francophone dans le processus décisionnel?

Comment la notion d'intérêt public inclut-elle les droits des francophones de l'Ontario?

Quel sera le cadre d'imputabilité quant aux services de santé en français en province et dans la région?

Les ententes d'imputabilité du ministère et du RLISS tiendront-elles compte de la capacité des fournisseurs de services et des sous-traitants à respecter la Loi sur les services en français?

Dans le contexte d'une décision d'intégration, quels seront les mécanismes et recours en place pour assurer le maintien des services en français et des établissements qui voient à la prestation de ces services?

Quels seront les partenaires impliqués dans la planification et l'élaboration des plans régionaux de services de santé en français?

Nous avons hâte de poursuivre le dialogue en ce qui a trait à l'accès aux services de santé par la population francophone de l'est de l'Ontario.

Je vous remercie, messieurs et mesdames, de l'invitation pour comparaître devant vous aujourd'hui. Merci.

The Chair: Is that all? C'est tout? Merci. We have about less than a minute each, and I would start with Mr. Wilson.

M. Wilson: Merci pour votre présentation. That's the extent of my French that I'm competent with, anyway.

M^{me} Robert: Merci, monsieur Wilson.

Mr. Wilson: I think your questions are excellent, and I would ask, through the Chair, that the minister get back to us on each and every one of the questions that are listed on page 5. That's not an unusual request: to get it in writing from the government. I couldn't ask them better. You obviously understand this issue much better than most of us.

The only other thing I would add is, is there a particular wording in any of the existing health acts that gives you the French-language-service protections that you're looking for? Is there a clause you can point to that should be in this act? I know this act, just as you say, makes a reference to the French Language Services Act. Do you want to put some thought to whether there's anything in particular, legalese there, that should go in here that would help the committee?

Ms. Robert: Definitely, Mr. Wilson; we'll look at that. I know the French Language Services Act does help us with the language to use in such a mandate.

The Chair: Your request, Mr. Wilson, will go to the minister, who will respond to us and to you in writing. So it has been recorded. Thank you. Madame Martel.

M^{me} Martel: Merci d'être venue cet après-midi. Ce matin, nous avons eu une présentation de la part de M. Morin, M. Grandmaître, M^{me} Lalonde, et aussi M^{me} de Courville Nicol. Ils ont parlé à propos du comité de travail sur les services de soins de santé en français. Je ne suis pas sûre si vous connaissez ce comité. Ils ont dit que le rapport est fini depuis quelques mois, mais la communauté francophone ne sait pas en ce moment le résultat. Alors, je voudrais savoir si vous avez vraiment des espoirs à propos de ce comité, parce qu'on ne connaît pas les conclusions en ce moment. Est-ce qu'il y a d'autres recommandations concrètes que vous pouvez donner au comité pour améliorer le projet de loi pour qu'il puisse vraiment répondre aux « concerns » à propos des soins pour les francophones en Ontario?

M^{me} Robert: Absolument, madame Martel. C'est vrai que nous savons que le comité de travail pour les services en français n'a pas été dévoilé, c'est-à-dire leurs recommandations. Alors, les recommandations que nous faisons aujourd'hui sont les recommandations que nous entendons de nos membres et de nos partenaires dont vous avez le nombre d'établissements et qui siègent pour la plupart autour de notre table.

Pour des recommandations plus concrètes, je pense qu'il faudrait peut-être regarder un modèle de gouvernance. Aussi, ce qui serait important qu'on voie est que le réseau s'est bâti dans la région de Champlain une expertise sur la planification et l'évaluation des services de santé en français pour sa population francophone. Je crois que c'est important de bâtir sur cette expertise et de l'améliorer et de la rehausser, parce que je pense que l'expertise est là.

Vous allez entendre aussi bientôt la réponse par l'alliance des réseaux. Il y a quatre réseaux dans l'Ontario qui feront une présentation devant votre comité sous peu, et eux, apportant sûrement des amendements beaucoup plus concrets à la Loi 36.

Le Président: Merci, madame Wynne.

Ms. Wynne: Thank you. I apologize for speaking in English. I actually wanted to follow on that question of the report that has been given to the minister. Our understanding is that suggestions have been made, that they are being reviewed and that the minister is looking for mechanisms that would do what you are recommending, that there be a voice for the protection of francophone rights in health care in the LHIN process. So that's what we're expecting will come out of that review, and we don't have any reason to expect that that's not going to happen. I don't know if you want to comment on that, but we're certainly waiting to hear the results of the review of the report that went to the minister.

Ms. Robert: Yes, the members of the committee have been held under confidentiality, and we respect the minister's decision. We know that the report has been translated. I think we are very confident, as the francophone population, of the recommendations by that group, because the committee was formed of very knowledgeable professionals and people of the community who understood the needs of the francophone population as it relates to health issues. Therefore, I am sure that their voices were heard in that committee, that they were able to voice the words of their regional area, because they were chosen according to region. Therefore, I think the francophone population of Ontario will have been heard through that committee, and we're quite hopeful that the minister is looking favourably upon the recommendations that have been forwarded.

The Chair: Thank you for your presentation. Have a nice day.

Ms. Robert: Thank you. Merci beaucoup.

OTTAWA COMMUNITY CARE ACCESS CENTRE

The Chair: The next presentation is the Ottawa Community Care Access Centre. Sir, you have 15 minutes total for your presentation. If there is any time left, we might be able to ask some questions and/or comment.

Mr. Tim Plumptre: I'll be less than that, you'll be pleased to hear.

The Chair: Lots of questions.

Mr. Plumptre: Shall I launch right in?

The Chair: Yes, please.

Mr. Plumptre: Sure. My name is Tim Plumptre. I'm the chairman of the board of the Ottawa Community Care Access Centre. I'm also here, to some extent, in my personal capacity in that I'm the president of a non-profit organization called the Institute on Governance, whose mission is to improve governance in public-purpose organizations. We work exclusively on public organizations. So what I'm bringing to you is a brief that's

based partly on my experience as chairman of the CCAC board here in Ottawa. I was previously the chairman of the board of the Hospice at May Court, which is a palliative care organization in Ottawa.

While I could have commented on lots of aspects of the legislation, I thought that you probably were going to get a lot of information from a lot of different people. So what my colleague is handing out here is just a short brief—it's only a couple of pages long—and a little bit of information on the institute.

The topic I have chosen to address you on is the question of the composition of the board of the CCAC within the new legislation. The brief says that there's a lot of things about the new legislation which we applaud. We think the government is moving in the right direction. I won't go through all of those things, because I know other CCACs have appeared before you and have said congratulatory things. So I won't repeat those.

But on the question of the composition of the board, there's a dilemma in any public organization around whether the board should be what's called "constituency-based" or whether it should be "competency-based," constituency-based meaning elected or chosen in some way to represent certain groups, geographic areas, linguistic groups, whatever, or whether the board should be selected based on some kind of capabilities that you want to have.

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From my reading of the legislation, the draft bill and also the commentary that's tabled on the website of the ministry, it wasn't entirely clear to me exactly what was intended as to how the boards should be established. It referred to the Corporations Act, and I didn't have time to review it, but I may be right in assuming that under the Corporations Act, as a non-profit corporation, it would be elected. I don't know whether you have the answer to that or not.

The Chair: Do you want a comment now or after? After. Make your presentation and we'll—

Mr. Plumptre: Anyway, you have basically those two options. The advantage of the constituency-based board is that it gives voice to different groups; it allows them to ensure that the different geographic areas, linguistic or other groups have some kind of say in the governance. The disadvantage is that you never know what you're going to get. You can get a collection of interesting people but who have no experience.

Indeed, a year or two ago I was invited to go over to Britain to address a seminar of what are called foundation trusts. These are very large hospitals with budgets in the hundreds of millions of pounds for which the British government is trying to establish new governance arrangements. They had decided in Britain that the boards of these hospitals should be elected by the community. So what you had was, to me, a somewhat paradoxical situation where you could have a £500-million corporation being run by a collection of people drawn from almost anywhere. One member of the boards of these foundation trusts said to me, "There are 71 different

ethnicities in my community, and I don't know which ones you'd suggest that we try and put on the board of the foundation trust."

Coming to the situation of the CCACs, I know there has been long debate over: Should the board members be appointed or should they be elected? I know a brief was submitted some time ago by the Ontario Association of CCACs that suggested three different approaches to the way in which the board might be comprised. What I'm doing here is coming down on the side of the approach that says a mixed board would probably make a fair amount of sense because you are running—and I'll restrict myself now to the Ottawa CCAC. If, as is intended, it would be amalgamated with the board of Eastern Counties and probably Renfrew, then you'd be looking at an organization with a budget of in excess of \$150 million and offices established here and there over a large geographic area and several hundred employees. So it's a fairly substantial operation, and I think it would make sense to have a board that had both certain kinds of capabilities on it and that you would probably want to secure through an appointments process.

My brief suggests that perhaps the appointments should be put in the hands of the local health integration network rather than in the hands of the government, because those of you who know about the current appointments process would know that it's not working very well. In fact, I could use a stronger adjective. The appointments to the boards have really not been working well, and I think members of the government are well aware of that, including the minister, who, the last time he addressed CCAC chairs, bemoaned how poorly the appointments process was working.

I know that political appointments are a complicated thing, and sometimes even getting MPPs to suggest good candidates can be difficult, but be that as it may, it is possible to appoint people in a constructive way. My premise is that the appointments would be done in a constructive way, and that should be mixed with a certain number of board members who are elected. If you look at the top of page 3 of the brief, I've listed some of the kinds of capabilities that you might want to have on a board that was managing \$150 million.

I'm finished.

The Chair: Thank you. We have a minute each, and I would start with Madame Martel.

Ms. Martel: Thank you very much for your presentation. We were just chuckling when you said that you knew how hard it was for MPPs to put names forward. Sometimes we're not asked; it depends on where you sit.

Mr. Plumptre: That could happen.

Ms. Martel: That's right. It sure does.

The government proposes to move to a model which—I'll give you my bias—I hope is elected from the community. What I saw with Bill 130 was a complete muzzling of the CCACs in terms of any information, discussion or community input, and I very much worry that that's going to be the exact situation with the LHINs. I hope it is democratically elected, and I'd like to see that for the LHINs. I think if you're really going to talk about

community control and community input, then having people appointed by the government doesn't cut it. Those choices and those folks have to come from the community.

That's my bias, for what it's worth, and you can respond to that in terms of either your experience at the CCAC or you said you were with a not-for-profit organization. I don't know how the board there is selected, if you've got some experience from that you want to share.

Mr. Plumptre: I wouldn't allude to our board in particular because it's not a good model for what we're talking about here. I'm very sympathetic to the notion of election. I'm just saying that I don't think the board should be comprised solely on that basis. We work with boards all the time—that's the business of the Institute on Governance—and I can tell you that there are a lot of boards I've worked with who were sort of wringing their hands, saying, "We got all these people elected, but the board's too big, the members are contentious, there's factionalism, they don't get along and they don't have the capabilities we need to do the job. So what do we do?" The answer is that it's hard to make it work if you don't have the capabilities you need.

So I'm very sympathetic to community input, but I'd make one other comment with respect to community input, and that is that there's more than one way of getting community input. I think it's an area of the legislation that's not been well thought through. There's a strong bias in favour of it, which is good, but you can get community input through various forms of community consultation, and I would encourage the government to think about the question of public consultation, what role it should play and who should do it. So I'm all in favour of it, but there are other ways to do it as well.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: I'd just like to let you know at this point what the plan is. It's to have a transitional appointment or mixed board, moving to a fully elected board for the CCACs. That is the plan. That's what's in the legislation.

Mr. Plumptre: That's what I thought.

Ms. Wynne: Having said that, the whole discussion of board governance is a long one. There are appointed boards and elected boards that are relatively dysfunctional or functional, depending on the individuals who are involved and the structures around them. So that is our plan.

Can you talk briefly about what you think some of the really important public engagement strategies might be? You just touched on there needing to be more. One of the things the minister really is interested in is how we can make that public or community engagement process more real than it might be otherwise. Have you got any specific suggestions?

Mr. Plumptre: The Chair's going to cut me off in about 30 seconds.

Ms. Wynne: I know, but just try.

Mr. Plumptre: That is the subject of a long conversation. Our institute did a little study of community engagement practices in regional health authorities in western Canada and elsewhere; in Nova Scotia too. It

was a real conundrum for these regional health authorities. They knew it was important. They had no training in it. The rural areas posed particular problems. We did a report to the ministry in which we flagged that as an issue—that and the orientation of board members, which I think is also very important.

I can't give you a quick answer to that.

Ms. Wynne: When was that report delivered to the minister?

Mr. Plumptre: That was delivered to the ministry staff about six months ago. It was the transition team: Gail Paech and those folks.

Ms. Wynne: Okay, so we'll refer back to that. There are some specific suggestions there?

Mr. Plumptre: Yes. It's suggested that it's an area of priority. Frankly, for me, personally, it's an area of particular concern. I've been thinking of going to the minister to try and tell him that the principles are great but the implementation is weak.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Thank you, sir. I think you put a lot of very thoughtful thoughts.

Mr. Plumptre: Those are the best kind.

Mr. Wilson: You should be elected for 15 years; you lose it after a while.

It's unclear in the bill, and perhaps the audience and everybody may be unclear. I ask Ms. Wynne this, I guess: Are we talking about election at large, like a municipal election, or are we talking about elections like we do for our hospital boards where people pay 10 bucks to become a member of the hospital corporation and then they're allowed to vote for their board of directors? Is it the hospital model?

Ms. Wynne: It's not general election, if that's what you're asking. It's a constituency—

Mr. Wilson: Okay, we need to clear that up.

What do you think of this? One of the boards that's controversial in my area is the Niagara Escarpment Commission. It has to tell people, "You can't build a house here. You can't add a garage here," and make some pretty tough decisions in preserving the beautiful escarpment. It has a mix of members appointed by cabinet, but the local municipalities that have a major stake are reserved seats on those boards also. Maybe some of the major health care players like the CCACs—maybe it's a conflict; I don't know—could also appoint people to the board. I know we don't want the boards to get too big, but maybe cabinet could appoint five of the nine—I know it's nine, minimum—and some of the major constituent groups, like the Ontario Hospital Association or the local CCACs or something like that could get together and appoint one member. Then you'd have constituent members as well as members at large. That's what they do with some other boards.

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Mr. Plumptre: Well, this could be another long conversation. I'm in favour of some process of general election from the community. Quite how it takes place, I'm not sure, because there is a problem, as happened at the Toronto East General Hospital, where you get certain

factions that take over the board, get their own people on to the board, and then that causes all kinds of other problems. The previous government had to put in a supervisor.

Mr. Wilson: You get partisanship on these boards and political parties start getting in there.

Mr. Plumptre: All processes are imperfect. I'm probably a little out of step with some of the other briefs you got, who probably said that pure election is the best thing since sliced bread. But without going into the details of how it could be done, I'm not sure I would favour municipal appointment of people to the board—at least, not very many. I've lived that; I used to chair the children's aid society board here in Ottawa, and what you got from the municipal level was quite mixed and often very partisan. What I like about the election side is that usually you get people who are deeply committed to the community and want to make a difference, who feel a connection there and aren't necessarily there for political advantage.

I'm sorry I didn't leave you a brief on community consultation, because we could have gone there, and I think it's really important.

The Chair: Thank you very much for your presentation.

MADELEINE LEBRUN

The Chair: The next presentation will be from Madeleine Lebrun.

Ms. Madeleine Lebrun: Thanks for having me. I'm Madeleine Lebrun. I'm with SEIU and with Red Cross home care. I've been hurt by the bids. Please try to understand, it's very emotional for me to talk about it, because I've been with the Red Cross for 20 years. In 1998, when Harris came into power, they introduced the bid. We used to be 500 members. We used to go in in the morning and we'd stay four hours with a client. We had time to give them a decent bath. We had time to feed them. We had time to take care of their pet sometimes. We had time to do housekeeping, maybe light, but anyway, we did. The people felt special and we treated them as special, with respect and dignity. But Harris, when that government came in, took that away from them and took that away from me, because now I have to go in, sometimes at 7 o'clock, wake up that client, "Get up and go for a shower now," when she's not ready. If I try to be nice, coax and beg—sometimes I almost have to shove that person in the shower because I have to be out of there within an hour and I have another client that's waiting for me. That's the sad part.

You want to introduce bids? You want to degrade people? That's what it comes down to. Right now, we're down to 55 members in Red Cross. Is that fair? No. I gave my heart, I gave my soul, I gave my strength to help the people, but you came in and said, "Get away. I will take over"—with no heart, no feelings. That's what hurts me, because it could be your mother or your father that I'm going to take care of. Would you like them to be

treated that way or would you like to be treated that way yourself? No. Those people went to war. Those people fought for freedom and for dignity and respect, and what do we do? We take that away from them and we say, "Too bad."

Money starts talking now. You know what happened? When the bid came along, they told the old lady, "If you want more hours, pay." Don't forget, they have a pension; that's all they have, most of them. Most of them have no children. I mean, the ones I'm working with have no children. You're telling me it's fair? It's not. When I hear the LHINs coming along, I see my sisters and brothers who work in the hospital; they're going to be treated the same way. You're telling me, "We can get maybe an MRI or a hip replacement; we could do about 20, 50." How far do they have to travel? Are you thinking of the family that has to go with them, miss work? That's not fair.

Right now this generation—I'm 55; if I have to take care of everybody—I can't miss work, because I'm full-time. Most of the home care people have two jobs, three jobs, just to support. Do they have a family life? They don't. I'm talking about experience now. I'm talking to my co-worker, as a home care person, a PSW. People don't understand. We travel; do I get paid for travelling time? No. Do I make a lot of money? No; I make \$12 an hour, and I'm not even sure if I have a job tomorrow. My hours could go up; my hours could go down. Why do I do it? Because I love it. I love the people and I think they deserve more than that. When people are sitting in the office—I'm talking about the heart right now—making judgements, making decisions without even walking in their shoes, that's not fair. That's not fair at all. I have to bid. Every three years I have to go up in front of a stranger again and offer my service again. I'm 55. I'm tired. I'm exhausted from selling myself to the lowest bid all the time. I don't get gas. People are not paying for my gas. Sorry, I have to apologize—I do get 22 cents a click, and sometimes I have to travel 30 minutes, 35 minutes. Is that fair? And if I don't do it, my boss is on my ass—sorry, my shoulder—and I hate that. I'm always under stress all the time. I go in to see that client: "Get moving, lady." "Sir, move it." You've got to remember, they're fragile; they're old people.

Again, I have to beg you, please don't go for the bids, because people do not understand. If my sister and brother have to go through what I went through, you won't have any more home care. You won't have anybody who wants to work for a hospital. Why? Because it's not worth it. The lowest bid all the time? I don't have benefits; I don't have a pension. I've got nothing. But I do have a heart. Is that recognized? Nobody cares. Nobody cares. That's why I'm very thankful that you guys let me talk. Finally, somebody is going to listen to us. Don't do the bid, because it's not worth it. You're losing life.

I'm going to tell you a true story. My father died, because what happened that time—in 1996, my father could do everything for himself. He didn't want a homemaker; he didn't want a nurse: "I can handle it."

The CCAC came to him, and says, "Mr. Sabourin, you need somebody to help you with your medicine." He knew what to do. We'd coax him, "Come on, Dad, you need that." Finally, he agreed. Four years down the road, they took away his service. My dad was confused. He didn't know which pill belonged, because he needed the dosette. The nurse had prepared his pills. He didn't know.

I remember fighting; I went to see my MPP: "Please, do something. Have an investigation. Do something." Well, they did. Tony Clement made sure the CCAC was accountable. They came to my father's house. He had cancer, he was diabetic, he was blind—what more do you want from him? He qualified. I asked the question: "Who made the decision that he was not qualified?"

And you want me to take the bids? You want me to go for the LHINs? You guys are going to decide that my dad was not worth it? Well, when they did an investigation, it was, "Oh, we made a mistake." But it was too late: My dad passed away because he got confused with his medication.

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Are you waiting for these things to happen again? When we lose a bid, we have to give our clients to another agency. In the process of doing that, there are missed visits, up to six weeks. I know; I visit those people. Why was it not reported? They're afraid that you might take away their service. That's the sad part. Do they have a voice in this LHIN? Do we have a voice?

You guys are going to have to understand that bids are no good, because you're hurting a lot of people. It's sad. I don't have much money; I only make \$12 an hour. I have to pay for my gas. I have to travel 30 minutes for one hour of work, and I found out they want to reduce that to 45 minutes. Would you like to take a shower in 45 minutes? Would you like me to give you a shower? You wouldn't like it, because I have to push you in, and that's a lot of stress on us. We get injured, and that's the sad part.

When the other bids came in, Red Cross lost the bid. Everybody cried. We didn't want to go to the other agency because we were well treated by Red Cross. The other agency didn't have an office. That lady was doing her work from the basement. I remember going in one time—they finally found an office—and they had a big box and all the clients in there. "You want to work? Pick your client up." Where's the confidentiality in there? There was none. Did somebody come and look at it? People don't care, and it's about time we start caring for people.

I'm talking about the handicapped too. Who's going to defend them? Who's going to do something about them? It's not the money. You're taking away their pride; you're taking away their dignity and their respect. I feel awful if they have to do that at the hospital. What chaos are we going to have? What tragedy are we going to have? We're going to have a lot.

That's it.

The Chair: Thank you for your presentation. We have about a minute each. I'll start with Ms. Wynne, please.

Ms. Wynne: Thank you very much for coming to tell your story. I just want to clarify that there's nothing in this bill that expands the competitive bidding process. I don't know where that information is coming from. There's nothing that says that's what we're going to do. I just want to assure you of that.

Ms. Lebrun: But could you have it in writing that it will not happen? That's my biggest concern, because I saw the disaster the bidding did. The homemakers are fighting among each other. I want our hours; I want to survive.

Ms. Wynne: I hear your issue, and we've certainly heard it from a number of folks coming to talk to us from the unions. I know this is a piece of information that is in the community. But what you need to know is that the legislation doesn't expand competitive bidding, and it's not our intention to set up a situation where competitive bidding will be expanded. That's the reality of the legislation, and it's also our intention.

The Chair: Thank you. Mr. Wilson.

Mr. Wilson: Well, it begs the question, then, how are you going to acquire services? I think that's what they want to know.

Ms. Lebrun: Yes.

Mr. Wilson: We'll take the blame for the past, but we also didn't make the promise to get rid of the competitive bidding process. The Liberal Party did, and you haven't done it. So you do have an obligation to be honest and say how you are going to acquire services in the future, and it's my job in opposition to point that out.

Ma'am, I appreciate your emotional testimony. Obviously, you've gone through it first-hand with your father. Some of what you said is a problem with the way bids are; some of it, in defence of the government, is rules that are set at Queen's Park. I'm an MPP and a former health minister, and I can't get my mother two baths a week. She won't mind me saying that publicly, because she's going to go public one of these days, and I'm her MPP. I've met with the executive director of the Simcoe county CCAC—Anne Bell, a wonderful person—but all she did was send the case manager for reassessment. At the end of the two-and-a-half-hour reassessment, she still can't get a second bath a week. So we're not all immune to what you've gone through. Yours was more serious.

Keep pushing, and maybe we can ask, through the Chair, for it in writing: How is the government going to acquire services in the future? You can stay silent in a bill, but you can't stay silent forever. Eventually, these things will be set up. If it passes in Parliament, you're going to have to tell people how you're going to do this.

The Chair: The request has been made, and the letter will certainly be coming to us. Then it's up to us to decide who to share it with.

Ms. Wynne: Except there is an answer. Accountability agreements that now exist between the service provider and the ministry will be between the LHIN and the service providers. That is the answer. I'm not sure you need a letter in order to get that.

The Chair: That's fine. He made a request, and we'll go through the normal process. Madame Martel.

Ms. Martel: Thank you very much for a very powerful presentation. It couldn't have been said any better than you have said it why cutthroat bidding has been so disastrous and why it should end.

Here's what we know: The Conservatives brought in cutthroat bidding, and the Liberals have kept cutthroat bidding in home care. They've been there for over two years now. There is nothing in Elinor Caplan's report that will end it. We see no evidence that Minister Smitherman will end it. It will continue in home care, and it will continue to be just as chaotic as it was under the Conservatives.

The second thing we know is that there is nothing in this bill that says competitive bidding will be used. There's nothing in this bill that says it won't. If the Liberal government means what it says, that LHINs will not acquire or purchase services through competitive bidding, then put it in the bill. I plan to find a way to move an amendment that will do just that, and then we will see how the Liberals vote and then we will see what the real intentions are of the government. If you don't want competitive bidding, move an amendment, put it in the bill, and make it clear that cutthroat bidding will not be used by the LHINs to purchase services.

The Chair: I wanted to say thank you for your presentation. I thought it was a very good presentation.

Ms. Lebrun: Thank you for hearing me.

EASTERN ONTARIO COMMUNITY HEALTH CENTRE NETWORK

The Chair: We'll move to the next one, which is from the Eastern Ontario Community Health Centre Network, David Gibson. Please have a seat, Mr. Gibson. You can start any time you're ready, for a total of 15 minutes.

Mr. David Gibson: Thank you very much for this opportunity. My name is David Gibson. I'm the executive director for Sandy Hill Community Health Centre, one of the oldest community health centres in Ontario, with over 33 years. I'm representing today the eastern region: both LHIN 10 and LHIN 11—that is, South East and Champlain—comprising 12 CHCs and one aboriginal health access centre.

The submission I have handed out will go into detail around some of the recommendations. For this brief presentation, I wanted to highlight some of the key principles.

With regard to Bill 36, the proposed Local Health System Integration Act, the Association of Ontario Health Centres and the Eastern Ontario Community Health Centre members have expressed support for the stated objectives of this health transformation strategy.

In communities across eastern Ontario—and that includes Tweed, Lanark, Kingston, Cornwall, Ottawa, Killaloe, Eganville, Beachburg, Portland—CHCs already play a very critical role in fostering health system transformation. They deliver cutting-edge interdisciplinary

primary health care, illness prevention and health promotion services to thousands of eastern region Ontarians. These services are combined with many complementary health promotion and disease prevention group programs, as well as primary care services. These health promotion messages and supports are extended into the community, building what we term overall community capacity.

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The Eastern Ontario Community Health Centre Network sees four overarching principles as critical to the success of the LHINs and would ask the committee to consider Bill 36 through the lens they provide.

The first principle is that Ontario requires a culture of health service integration and coordination, not merely a system navigation mechanism, as stated. Every door is the right door to services. LHINs should facilitate ongoing dialogue among all levels of care provision through opportunities such as, but not limited to, health service providers. A multisector approach is preferable and is grounded in a focus on the broad social determinants of health, which means more than just physical health but things like housing, education and food security. Integration also needs to be properly resourced. CHCs are interdisciplinary and have for many years been working in that system, and there is a cost, obviously, that needs to be appropriately resourced.

We feel strongly that health care providers in various sectors assisting a client to receive the appropriate care they need is the outcome of an effectively coordinated system, not the role of an individual sector, organization or individual. Each has a role to play in achieving a positive outcome. A culture of system integration and coordination is needed, not any single system navigator.

It is also imperative that this committee recognize and make accommodation for the health service providers who are not included within Bill 36. System integration and coordination must be inclusive of public health authorities and all primary care models and providers. This critical link will facilitate a true integrated and coordinated approach to patient care follow-up in and out of various health access points.

Principle 2: Ongoing and broadly defined community engagement by LHINs is key to achieving true local integration. The words of Margaret Mead were, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." We need to support community governance as a method of ensuring rich client and community engagement processes. Community governance cannot mean governance of all health services by a regional board. We do not support the model of community governance whereby all health services in a health region, including hospitals, long-term care and CHCs, are managed by a single board.

"Community" should not exclusively be defined as health service providers. It should include client and client group engagement and should ensure that as a basic tenet. Integration orders and institutional changes in services should be undertaken through a filter that would

ensure that clients will be able to access services and that resources follow those clients to new service locations.

Challenges to any integration order should also allow a 90-day period and not a 30-day period, for this is too little to allow many community-based organizations to respond effectively.

In addition, I would like to highlight another key recommendation. I would like to propose an addition to part V, subsection 25(3), of a clause stating, in effect, "No integration decision shall permit the elimination of community governance structures except on a case-by-case basis where a single health service provider is party to an integration order with another single health service provider."

Community governance is a fundamental cornerstone to the success of CHCs and many other community partners. Community governance encourages and promotes local action and responsibility. It is perhaps the truest form of community engagement and provides an accessible and equitable mechanism through which accountability to recipients of the health care services—those persons who in effect own the health system—is achieved. Community-governed organizations are able to transmit political pressure and social change upward to promote higher-level policy change. Controlling hep C and HIV requires epidemiology, health service providers and citizen engagement. This form of governance and accountability cannot be replaced by one that defines community narrowly as the community of health providers.

Principle 3: A continuum of care approach for health service coordination and integration is critical to ensuring that services reach all clients, particularly those facing barriers in accessing services.

It is important to note that proximity of services does not necessarily mean duplication. Community health centres, for example, in Ottawa and across Ontario represent geographic and specific community needs. Barriers to access need to be borne in mind to ensure that services reach diverse target populations. One-way-valve provisions are needed. It is not responsible nor respectful to organizations to take money that has been deemed "community" and transfer it into institutional acute care or long-term-care settings. Similarly, the provision of protecting community groups from hospital deficits is also needed. It is not fair to have a hospital download a community service without those funds sufficiently providing for that community service.

Principle 4: Provincial health system standards, including standards for all primary health care models, are necessary to ensure equity in the system and effective planning at the LHIN level and across LHINs.

The Eastern Ontario CHC Network recognizes that there are certain HR anomalies with the LHIN scope of authority. For example, community health care physicians are the only primary care model included within LHINs, but all other primary care models are currently outside of LHINs. The development of an HR planning tool that ensures equity across models and for all providers needs to be in place. Physician compensation

agreements, as an example, should also pertain to all providers of all models. LHIN integration health service plans should also be informed by a provincial plan and developed in partnership with all health sectors, whether they are inside or outside of the LHIN. The other point is that health professional advisory groups should have representation from different models and not just expressly within the LHIN.

In conclusion, the Eastern Ontario CHC Network supports the intention behind the Local Health System Integration Act. We hope that this legislation will ensure that the broad determinants of health are taken into consideration in its consultation processes. The fact is, every door should be the right door to service. This means that the process for community engagement needs to be broadly defined and inclusive of more than just health service providers and organizations. It also means that all models of primary health care and public health authorities need to be included in the planning process, as well as the communities that they serve. The planning process also needs a continuum-of-care approach for health service coordination and integration.

The Chair: Thank you. We have 30 seconds each.

Mr. Arnott: Thank you very much for your presentation. I think you've informed the committee with some very good advice, defining four key principles that you think need to be covered in the approach to the legislation. We appreciate your sincere interest in being here.

Ms. Martel: I don't have questions. I just want to say that we've heard a similar presentation, and I appreciate particularly the actual wording for the proposed amendments. I'll take a look at those, because I think they would go some way to dealing with what you want to have dealt with. I just wanted to say that I appreciate the work that has been done by the association to bring forward the amendments through the presentations.

Ms. Wynne: Thanks very much for your recommendations. What do you see as the practical potential for improvement? Can you give, in 20 seconds, I guess—

Mr. Gibson: The improvement?

Ms. Wynne: Well, the CHCs work very well. You're a model, obviously, that we really support. So when you look at the LHINs and you see the potential, what's the thing that you think can—

Mr. Gibson: My recommendation is to include all primary health care models—CHCs are a founder—and public health in terms of that. I think that's the improvement if you're going to have cross-sectoral planning.

Ms. Wynne: Okay. Thanks.

The Chair: Thank you again for your presentation.

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ONTARIO NURSES' ASSOCIATION, LOCAL 83

The Chair: Next, we have the Ontario Nurses' Association, Local 83, Ottawa Hospital, Frances Smith and Éric Drouin. Welcome. You can start any time.

Ms. Frances Smith: Thank you. My name is Frances Smith, as you heard. I work as a registered nurse in the intensive care unit at the Ottawa Hospital, and I'm here to speak on behalf of Local 83.

The impact of LHINs and Bill 36 is only a concept at this point, but already individuals and organizations are identifying potential hazards in this legislation associated with the lack of a human resources strategy, the potential privatization of health care, and the disruption of health care services.

ONA Local 83 represents approximately 3,500 nurses at the Ottawa Hospital. This gives us the distinction of being the largest local in Ontario, with multiple sites across the city servicing the greater Ottawa region and western Quebec. Through the amalgamation process in 2000, nurses and patients have adapted to a complex organization which delivers highly specialized health care. The Ottawa Hospital also includes the University of Ottawa Heart Institute, the Ottawa Hospital Regional Cancer Centre, the Rehabilitation Centre, plus the Ottawa Hospital Research Institute.

Our primary concern is patient-accessible health care in our region. As nurses, we struggle every day to ensure that members of our community receive excellent nursing care. The transfer of non-acute services will impact all within our community. The Ottawa Hospital has already seen the privatization of the in vitro fertilization clinic, and the Children's Hospital of Eastern Ontario has lost its poison control centre to Toronto. These are just two examples of health care services that are either for-profit or are being outsourced to other communities outside our living environment.

LHINs cover large geographic boundaries. Smaller community hospitals may be forced to close because of unfair competition from larger urban hospitals. Our patients may have to leave their communities and families in order to obtain health care. Mr. Smitherman has publicly stated that there will be no competitive bidding process, but the legislation in Bill 36 does not affirm that position.

The outsourcing of services will be a burden to an aging population, in time, travel and financially, if they are expected to visit multiple locations for services—a blood test here, across town for an X-ray, and then a visit to the physician somewhere else—increasing frustration in an already complex health care process.

The amalgamation of the Ottawa Hospital was a painful experience for many of our employees. Bigger is not always better, and the potential that LHINs could once again disrupt their workplace is frightening and discouraging to many of our members. The proposed integration will cut costs by cutting and merging services, not by controlling the real health care costs such as pharmaceutical drugs and medical equipment.

The potential fractioning of the health care worker will reduce access to resources, education and the interaction necessary to maintain a vibrant, knowledgeable and excellent health care workforce. The environment we work in is just as important to learning as for academics and educators.

Unelected LHIN boards appointed by the government will get control of more than \$21 billion to fund health care. Communities will have little opportunity to challenge decisions made regarding mergers or cuts from local hospitals and agencies. There are no checks and balances, but there is liability protection for the LHIN boards. So what recourse does the public have, should they disagree with a decision?

LHINs will determine the health care priorities and services required in local communities, yet the legislation does not reflect this. It remains silent and is not proactive in protecting community rights to participate in the decision-making process. The Ontario government is creating another level of bureaucracy that will increase costs and reduce efficiency.

We encourage the members of this panel to seriously review and correct some of the deficiencies which have been identified by many of the participating speakers across Ontario. The government has not done the necessary groundwork to protect the public or the front-line health care workers. This legislation requires further review and answers to questions necessary to protect the public. We, as health care workers, must prevent the escalation of private health care and honour the Canadian principle that health care is a fundamental right. We have an obligation to all of our patients to participate in the review of Bill 36 and ensure accessible health care for all our citizens.

Thank you, ladies and gentlemen.

M. Éric Drouin: Bonjour, délégués distingués. Mon nom est Éric Drouin. J'habite à Orléans depuis plus de 30 ans. Je viens ici aujourd'hui comme électeur public. Je suis un infirmier autorisé dans un hôpital, et je travaille dans le département d'urgence depuis plus de 10 ans.

Les RLISS, réseaux locaux d'intégration des services de santé, et le passage de la Loi 36 affecteront la qualité des soins directs et indirects dans ma communauté. Comme infirmier à l'urgence, les changements, les modifications de pratique et l'adaptation de mon travail font partie de mon quotidien.

Ma langue maternelle est le français. La Loi 36 ne prend pas en considération l'importance et l'impact qu'une restructuration des services de santé pourrait avoir sur l'accès des services de santé en français.

Une restructuration des services de santé ouvre la porte à des entreprises et entrepreneurs à continuer à éroder notre droit à être servi en français. Ceci affectera directement la qualité des soins de santé en français. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

Les services privés/semi-privés vont seulement voler, oui voler le personnel déjà établi dans les services publics. Ceci va seulement contribuer encore plus à augmenter la pénurie des ressources humaines des services publics. Et pour quoi? Pour un profit. Un bon exemple : la nouvelle clinique privée Copeman, qui dit pouvoir augmenter les services de santé. Où va-t-elle aller prendre les ressources humaines, les infirmières, les médecins, les technologues pour être en position d'ouvrir

ses portes? Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

En réalité, ceci est un déjà-vécu dans d'autres pays qui ont déjà installé un système privé/semi-privé de santé. Mais regardons un endroit comme Ottawa, qui a—ressource disponible—présentement le personnel pour faire 100 chirurgies de genoux par mois—un chiffre arbitraire comme exemple. Tout à coup, avec le pouvoir de la Loi 36, on centralise, déplace les services qui ouvrent la porte au côté privé. Un entrepreneur, souvent un groupe de médecins et chirurgiens, pourra ouvrir un établissement privé pour offrir des chirurgies de genoux. Ces mêmes chirurgiens viendront du service public, et on sait bien qu'il y a déjà un manque de chirurgiens spécialisés dans les os. Cet établissement privé ouvrira les portes et aura une capacité de faire 50 chirurgies par mois. Mais c'est le même chirurgien qui faisait les 50 chirurgies par mois dans les services publics. Ce chirurgien ne peut pas être à deux salles d'opération en même temps. Qui fera ces 50 chirurgies de genoux dans les services publics?

La liste d'attente ne changera pas avec la privatisation des services. La région d'Ottawa fera encore 100 chirurgies—50 dans les services publics et 50 dans les services privés. Ce qui changera, c'est que le public avec de l'argent, les riches, pourra payer pour les services privés et couper devant la ligne, avec aucune réduction dans le temps d'attente pour ce même service de chirurgie de genoux. Rendus à la fin, les riches profiteront et les moins fortunés souffriront. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

Aujourd'hui, les cliniques privées ou semi-privées utilisent la carte de santé. Une visite d'un patient pourra comprendre des tests sanguins et des rayons X. Ensuite, on ferme la clinique car les heures de bureau sont seulement de 8 heures à 21 heures, du lundi au vendredi. Alors, ce même patient peut se retrouver à l'urgence de l'hôpital. Puisque l'hôpital n'aura pas accès aux tests sanguins et aux rayons X faits dans la clinique privée, il devra tout recommencer à nouveau. Évidemment, il passera encore par le système de carte de santé, et les coûts seront encourus en double. Un système électronique sauvera beaucoup d'argent au service de santé, de l'argent qui pourra être réinvesti pour continuer à améliorer les services de santé publique.

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Le RLISS pourrait plutôt concentrer ses efforts à assurer une collaboration des services de santé en utilisant un service électronique central qui utiliserait la carte de santé comme mode de contrôle et paiement aux institutions utilisées. Ce système électronique pourrait contenir tous les rapports de sang, rayons X, rapports de spécialiste—neurologue, orthopédiste, chirurgien—rapports de congé d'un séjour à l'hôpital et toutes prescriptions de médicament. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre.

En fermeture, le RLISS va-t-il regarder et prendre charge de tous les services de santé, et non exclure les

médecins, agences de santé publique, services ambulanciers, laboratoires et les médicaments de prescription? Diminuer la duplication et même le quadruple de tests sanguins, rayons X? Va-t-il limiter les duplications de visite chez un spécialiste? Va-t-il apporter un contrôle sur les prescriptions médicales lorsqu'un patient visite une clinique privée une journée, ensuite un médecin de famille, ensuite un spécialiste, et à la fin l'hôpital? Quatre visites pour le même problème médical, quatre tests sanguins, un à trois rayons X et certains tests plus spécialisés doublés, multiples prescriptions.

La privatisation est un mot très alarmant. Les autres pays qui ont adopté ce système le regrettent aujourd'hui. Le RLIS a le privilège d'apprendre des erreurs des autres pays et de continuer de suivre conformément la Loi 8 et de respecter les principes des services de santé publique et non privés. Pourquoi investir notre argent des taxes pour le donner au côté privé pour y en faire des profits, le côté privé qui va seulement diviser en deux les ressources humaines précieuses—infirmiers, docteurs, techniciens et services de support—déjà en pénurie?

Une personne peut devenir malade 24 heures sur 24, sept jours par semaine. Si on a l'idée de continuer à dépendre sur des services privés seulement ouverts lundi au vendredi, les services de santé ne seront jamais arrangés. Pour ceux qui pensent que le système privé arrangera les services de santé, un mot d'avis: ne devenez pas malade vendredi soir vers 21 h 30. Il n'y aura pas de service privé pour vous aider. Il y aura seulement des services publics qui vous seront toujours disponibles. Où est la responsabilité gouvernementale? Les services de santé publique ne sont pas à vendre. Merci beaucoup.

The Chair: Thank you. There is about a minute and a half total. Mr. Ramal: 30 seconds, please.

Mr. Ramal: First, thank you for your presentation. I want to ask you two questions, basically. First, what do you think when we have unelected, appointed people working from Toronto, controlling all the health across the province of Ontario? What if an appointed body looked after the LHINs across the province? We have similar situations. Even better now, we have local people appointed by the ministry instead of a body appointed by the minister who sits in Toronto.

For the French questions: C'est plus important pour notre gouvernement, pour notre ministère d'avoir des services en français, parce que notre ministre a parlé avec la communauté francophone de l'Ontario et a écouté chaque recommandation.

Ms. Smith: I guess one of the concerns I would have, speaking to your first question, is that I believe that the LHIN boards will just set up a distancing of the government from the responsibility they hold in administering health care, the health care dollar. I think that, as a result of the decisions the LHIN boards will be forced to make within their different communities and regions, the minister will be able to enact things within health care that the communities don't want to be and should not have to be responsible for.

Mr. Ramal: He can do that now from Toronto if he wants to.

Ms. Smith: Well, we can also do something about it in four years' time, when it comes to a vote.

Mr. Ramal: I'm talking about technical stuff. You're talking about technicalities. When you have a board or a ministry controlling the whole province from Toronto—now you have local control for team units in Ontario—same things.

M. Drouin: Pour la deuxième question sur les services en français, en lisant la Loi 36, et je ne suis pas un expert, définir dans la loi et référer que les services bilingues en français soient reconnus—le dire, c'est tout bien, mais l'avoir écrit dans la loi peut offrir un peu de respect de la langue française.

The Chair: Merci. Mr. Wilson, please.

Mr. Wilson: I would just say thank you very much. As I said to the nurses' association this morning, we don't always agree, but there's much we agree on in terms of opposing parts of this bill.

As a former health minister, I know when I've met my match, so I'll just say thanks again.

The Chair: Madame Martel.

Ms. Martel: Merci pour votre présentation.

I want to focus on section 33 of the bill. It's the section that allows for integration by regulation. I'm going to focus on it because you represent nurses at the Ottawa Heart Institute, and that's referred to directly in this section. It says, "The Lieutenant Governor in Council"—that's going to be cabinet or the minister—"may, by regulation, order one or more persons or entities that operate a public hospital within the meaning of the Public Hospitals Act and the University of Ottawa Heart Institute ... to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity"—we don't know who that is—"on the prescribed date," and we don't know when that is.

That's the section that allows the minister to contract out non-clinical services, which also aren't defined. Given that the University of Ottawa Heart Institute is specifically referenced in that context, does that give you some cause for concern?

Ms. Smith: Oh, yes, definitely. It gives us all a lot of cause for concern. You have to remember, I'm an intensive care unit nurse. I love what I do. I want to be able to continue to do it. You have absolutely no idea how difficult it was for us when they amalgamated the hospitals. We see so much pain and suffering today in our jobs with the people that we look after. We certainly do not need anything to make it any worse for the people who are trying to get the health care they require, in making them travel all over the region in order to obtain that health care. We want to ensure that we can give the care that we know people need as our patients.

The Chair: Thank you very much for your presentation.

ONTARIO COUNCIL OF HOSPITAL UNIONS

The Chair: The next presentation is the Canadian Union of Public Employees, CUPE, Cornwall; Ontario Council of Hospital Unions. Helen Fetterly will be speaking to us. Welcome.

Ms. Helen Fetterly: Thank you.

The Chair: You can start any time you're ready.

Ms. Fetterly: Good afternoon. I'd like to thank the committee for the opportunity of presenting this afternoon. My name is Helen Fetterly. I'm the secretary-treasurer of the Ontario Council of Hospital Unions, CUPE, and I've also been a health care provider in Ontario in the community of Cornwall for the last 35 years. With me this afternoon is Doug Allan from CUPE.

The Ontario Council of Hospital Unions, OCHU, is the hospital bargaining council for CUPE in Ontario. We bargain a central collective agreement with the Ontario Hospital Association. OCHU represents approximately 25,000 hospital employees in service and office hospital bargaining units from one end of the province to the other. We represent cleaners, registered practical nurses, dietary workers, operating engineers, secretaries, ward clerks, porters, carpenters, cooks, personal support workers, lab assistants and many, many others. Most OCHU members are women.

We note that, while hospital spending on certain other areas—for example, pharmaceutical drugs and supplies—has risen, spending on Canadian hospital support services has shrunk as a percentage of total hospital spending. In recent years, support spending has even shrunk in terms of total dollars spent.

OCHU, the Ontario Council of Hospital Unions, takes great pride in our long-standing campaigns in favour of universal, accessible, comprehensive, publicly funded and publicly delivered health care. We are very concerned about the impact of Bill 36 on many of these principles, and so have taken some pains in bringing our concerns to the community. Our written submission discusses a variety of issues connected to the bill, and we ask that you read it carefully, as we can only discuss a limited number of issues in our oral presentation.

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The LHINs are local in name only. The bill would grant little real power to local communities and providers to make decisions. Rather, it transfers control over local community-based providers to the minister and cabinet and to their agents, the LHINs. The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

The government describes the legislation as a made-in-Ontario solution that would give power to the local level. It distinguishes this reform from regionalization in other provinces, as LHINs will not directly deliver services. In fact, the government's reform borrows problem areas from health care regionalization in other provinces

and combines them with problem areas of health care restructuring in England. It would create a new layer of bureaucracy that would (1) be unaccountable to local communities, (2) reduce provincial government accountability for the largest part of the budget, and (3) create a purchaser-provider split that will undermine health care and social services.

The LHINs cover very vast and diverse areas. The LHIN boundaries override municipal, provincial and social boundaries. The LHINs are not local, they are not based on communities, and they do not represent communities of interest. As a result, they lack political coherence, so it will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

The autonomy of the LHINs from the government is very modest. The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose this even if the LHIN does not agree to the agreement. So LHIN boards will be responsible to the provincial government rather than local communities.

This model is similar to changes made to community care access centre governance in 2001. The key there was to replace community boards with government-controlled boards. CCACs were taken over by the provincial government in 2001 and they immediately ceased pointing out to the public their need for adequate funding. The result? Their funding was flatlined for years and home care services were cut back dramatically. Tens of thousands of frail elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 1, 2001, to April 1, 2003, and a cut of six million hours in services, a 30% drop. Needless to say, this is a very poor model for LHINs to follow.

LHINs will also insulate government from decisions to cut back or privatize services by creating another level of bureaucracy that will catch much of the flak. The government will control the LHINs, but the LHINs will actually implement the decisions. They will be the first targets for popular discontent, even if their actual autonomy from government is more imaginary than real.

Bill 36 also gives LHINs and the government a wide range of tools for restructuring public health care organizations.

First of all, the LHINs have their funding powers to facilitate consolidation: section 25 of the bill. They also have accountability agreements with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and cabinet to force consolidation.

LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service: subsection 26(1) of the act.

The minister may order not-for-profit health service providers to cease operating, amalgamate, or transfer all of their operations: section 28. Notably, for-profit pro-

viders are exempted from this threat, creating an imbalance between for-profit and not-for-profit.

The bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization: subsection 33(1). The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of "non-clinical service," and so this definition may be a matter of considerable controversy.

The government refers to this restructuring as "integration," stating that the goal is the creation of seamless care and a true health care system. But the LHIN restructuring will not unite hospitals, homes, doctors, labs, home care providers and clinics as in regional health authorities in other provinces. Indeed, the LHIN purchaser-provider model will increase competition between providers, not reduce it. The plans to spin off work to for-profit corporations, private clinics and regionally based support service providers will mean more fragmentation and less integration.

With service cuts, there is a real threat to local health services. At first, the government talked only of integrating support services. But cutting support services is dangerous—hospital-acquired infections have already killed thousands in Canada every year—and inefficient, as it often requires more highly paid staff to take over the functions formerly done by support staff.

An early example of support services consolidation is HBS—Hospital Business Services. With government support, 14 hospitals in the greater Toronto area planned to regionalize supply chain and office services by turning the work over to another new organization. HBS indicated to us that it would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations, and sever 20% to 25% of employees. One participating hospital has just told our members they are only waiting for Bill 36 to pass for this large-scale contracting out of our work to begin. This is just the beginning of a major change across the province that will have far-ranging consequences for workers and local communities. Many more such plans are in the works.

Like so much restructuring, these moves will have a major negative impact on hospital support workers. They certainly will not create seamless care for the patients. Instead, they will create more employers and bring more for-profit corporations into health care. In many respects, it will create more fragmentation.

As well, clinical services are threatened. When the government pushed for cost containment in late 2004, the hospitals insisted that an exclusive focus on support services would not satisfy the cost savings demanded by the government; the savings would also require clinical cuts. The battle over the cuts has proceeded for some time, usually in secret. By April 2005, the government as much as admitted that clinical services would be consolidated or cut, with the health minister publicly calling for the centralization of hospital surgeries: "We don't need to do hip and knee surgery in 57 different

hospitals." Instead, he suggested that about 20 might be appropriate. That is about a 60% cut. The minister went on to indicate that hospital specialization is coming: "Each hospital in Ontario will be given an opportunity to celebrate a very special mission but not necessarily operating with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travel to multiple sites for health care services.

With respect to protection of local services and access to care, integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability through the LHINs will make it easier for government to implement these threats.

As well, a new form of health care privatization: Bill 36 provisions do not ensure that the LHINs, the minister or cabinet will preserve the public, not-for-profit character of our health care system. Indeed, these bodies would now be armed with the legal authority to privatize large parts of our publicly delivered health care system. Moreover, LHINs will create a split between the purchaser of health care services and the provider.

I'm just going to finish up and take the one minute I have left.

I also want to talk a bit about stopping privatization in health and social services and building co-operation. Privatization and decreased co-operation between providers are major threats of this reform. Instead of integration, privatization will bring "disintegration" with the various providers in competition to win contracts. Above all, competitive bidding and privatization should be specifically excluded in the legislation, based on the disastrous results they have already brought in Ontario health care.

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For all these concerns, we believe this bill and the government's attempt to restructure health care need to be rethought. We have made some suggestions of how health care reform could unfold, but we urge the government to take a considered and consultative approach. The public was not informed before the last election that the government would embark on the form of health care reform it has taken. We believe that a better approach would be to consult with local communities, health care workers and the public about how health care should be reformed. That would be a much more satisfactory and a much more democratic process.

Thank you.

The Chair: Thank you for your presentation.

OTTAWA COUNCIL OF WOMEN

The Chair: The next presentation will be from the Ottawa Council of Women. We have Luba Podolsky and Marianne Wilkinson. Ladies, you can start whenever you're ready. There is a total of 15 minutes available.

Ms. Marianne Wilkinson: Thank you. I'll just introduce our organization and then Luba will talk about the health aspects.

The Ottawa Council of Women is a federation of organizations of women, or of women and men, and of some individual members; it is itself a federate of the Ontario council of women and of the National Council of Women, which is in turn a federate of the International Council of Women. The Ottawa Council of Women is primarily an advocacy group. It's a non-governmental organization, democratic and non-partisan. It is funded by donations and by modest membership fees. It was founded in 1894.

The council provides a platform for members' concerns to be heard, discussed and presented to a wide audience, and to the appropriate level of government. Policy for the council is established through a resolution process. Issues of concern become subjects for resolutions which are sent to national or provincial councils and brought to a vote at their annual general meetings. Accepted resolutions become policy and form the basis for our annual briefs submitted to the federal and provincial governments. This grassroots participation has served us well for more than 100 years.

Ms. Luba Podolsky: The health committee of the Ottawa Council of Women has been actively involved in gathering information, informing our members and contributing to policy formation for both the provincial and national councils on matters pertaining to health. Our representatives attend board meetings of the Ottawa Community Care Access Centre as observers and participate in the community advisory committee of the Ottawa Hospital. In the 2001 brief presented to the government of Ontario by the provincial council, there is a resolution advocating "integrated funding, management and delivery of health services" which proposes a LHIN-like development. We also have policy supporting both local accountability for health care and the need for health promotion. We are therefore pleased that the Ministry of Health and Long-Term Care of Ontario is moving in these directions.

We want the LHINs to work and to help keep OHIP as a strong public system under the Canada Health Act. Bill 36 is the proposed legislative framework for the LHINs, and therefore it must be written correctly as changes would take a lot of time and be difficult. The preamble to Bill 36 is most encouraging. It states:

"The people of Ontario and their government

"(a) acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve;

"(f) believe in public accountability and transparency," and also that there will be committees established to reflect this vision. The promise that there will be no restriction on patient mobility we interpret as a promise that patients can expect service as close to home as possible.

Now our concerns about Bill 36: The primary one is local accountability. This is a major concern. The pro-

posed Bill 36 spells out accountability by LHINs to the minister and by the ministry to LHINs, but there is no accountability required by the LHIN to the community. This has been stressed by several other people today already. The public may have access to some meetings and may receive reports, but that is far from accountability. There is no representative from local levels of government on the LHIN board. All are appointed at the pleasure of the minister in far-off Queen's Park. We request inclusion in Bill 36 of a means to empower municipalities or local governments to have full participation in LHINs decisions.

There is also no provision in Bill 36 for a voice for patients. It seems that the Ontario government could run a perfectly good health care system if it didn't really have to worry about patients. There is no provision for the voice of patients. Part II, clauses 5(c) and 5(d), outlining the objects of the LHINs are welcome and appropriate but need to be expanded. What formal channels for community input are envisioned? How must patient concerns about services be dealt with? These questions should not be answered in the regulations, which can be changed easily by a different government. We need more detail in the bill to ensure that the stated objectives are met. We think that if it's not in the bill, it's not going to happen.

Part III, planning and community engagement: We wonder about the meaning of the term "engagement." Clause 16(1) implies, but does not spell out, who is within the community of persons and entities that shall be engaged while the LHIN is setting priorities. Clauses 16(2) and (3) are quite specific. We request the addition of a 16(4), to be something like: "Each LHIN shall establish a consumers' advisory committee consisting of representatives of community groups registered as such, which will be consulted when plans are being developed and priorities are being set for the delivery of health services."

Our Champlain district LHIN covers a very large geographic area. There must be clauses within the bill to ensure that local needs are met, that consumers throughout the area feel they have a stake in their health care delivery. How will the Champlain district LHIN be truly local? How will patients navigate such a complex system?

The scope of LHINs: Bill 36 deals with management of disease, but says very little about the management of health. What is the connection of the Ministry of Health Promotion to the LHINs? The community health centres in Ottawa have developed programs to deal with many aspects of health. Perhaps our LHIN could benefit from their example.

Privatization: Another concern of ours is the possibility that hospitals may lose control of staffing to a competitive bidding process by which agencies contract to supply staff. Hospitals could be ordered to do this to try to save a few dollars, even though the staff of a hospital determines its success. This would impact quality of service and flexibility of action of the hospital, and the stability and loyalty of its staff. We request a

guarantee written into the bill that hospital staffing will remain an internal matter under the control of the hospitals.

In part V, the minister may, in sections 28 and 29, amalgamate, merge or close non-profit groups that receive funding from the government. Why are non-profit groups specified? Surely the same rules should apply to for-profit groups, or are they not eligible for government funding? Perhaps they have been written right out of the bill. We support integration of services, but would like some clarification on this point.

We look forward to the successful implementation of a LHIN that will be responsive to the needs of its communities and supportive of a public health system within the Canada Health Act. Thank you.

The Chair: Thank you. There is about two and a half minutes each, and we'll start with Mr. Arnott.

Mr. Arnott: I want to thank you very much for your presentation, and if you could pass along our appreciation to your colleagues at the Ottawa Council of Women for the thoughtfulness that's gone into this presentation and the ideas that you've put forward, some of which I would venture to say we have not yet heard.

First of all, the whole idea of, what is the role of the Minister of Health Promotion in this thing? I think that's something that hasn't come up so far, and of course the Minister of Health Promotion would want to ensure that his ministry has a role in all this.

Secondly, you raise the issue of local accountability and you suggest that there is no assurance that representatives of a local community or a local municipality will be included in the LHIN board. Do you think municipal government should be given the opportunity to appoint a person to represent the community on the LHIN board, in some cases?

1510

Ms. Podolsky: I think so, personally, but it's going to be difficult because it's such a huge area. How do you choose a representative from that huge area? Perhaps there have to be representatives chosen for each committee meeting, when the committee meeting is in a specific locality. There has to be some kind of mechanism for making this local. We envision the LHIN as being a problem-solving agency, not as much a controlling agency, and in order to solve problems you have to get people together and discuss these problems. We really can't see that written into the bill.

Mr. Arnott: Some groups have suggested that there should be some sort of an appeal mechanism, so that if groups or individuals are dissatisfied with a decision of a LHIN board, there would be an independent appeal board that they could make their case to. Do you think that needs to be included in the legislation as well?

Ms. Podolsky: Yes. But even before that, before you make an appeal, you have to have some input into what the rules are and what the process is. The consumers of health care have to have some kind of an input into this whole process, and there's nothing in Bill 36 that guarantees such an input. You've been hearing mostly from health care providers, and their input is very valuable, but

there isn't very much said from the point of view of the consumer. I think Madeleine came the closest to that, and we think that's a sad omission.

The Chair: Thank you. Madame Martel.

Ms. Martel: Thank you, both of you, for the presentation and for the long, long history of service to the community. I appreciate that.

You said your major concern is local accountability. It is very clear that the accountability is all about accountability to the minister, not to the local community. I just want to reinforce some of this again, because it's cabinet or the minister that creates or dissolves any LHIN. They are appointed by the government. Their remuneration is set by the minister. The chair and the vice-chair are appointed by the minister, not by the board. The LHIN is explicitly defined as an agent of the crown right in the legislation, not an agent of the community. The LHIN enters into accountability agreements with the ministry and service providers, but there's nothing with respect to their accountability back to the community. They are funded by the government on the terms and conditions that the minister considers appropriate. They can fund health service providers, but that has to be in accordance with government requirements. Also, each LHIN has to develop an integrated service plan, but that plan has to be in accordance with the plan that's put forward provincially, and we haven't heard anything about the details of how that plan is being developed right now—who's involved, whose input is being considered etc. So the sad reality is, while the government would like to say that this is about bringing control closer to the folks so you get better health care close to home, this bill centralizes power in the hands of the minister and cabinet more than any other health bill ever has.

If you were writing a bill that actually talked about accountability back to the community, what might be some of the changes that you would see would be necessary to actually ensure that the LHINs have some accountability to the community, not all of their accountability back to the minister?

Ms. Wilkinson: We think that there should be appointment through community consultation. The community itself should be involved in selecting the people to be on the LHIN, so that they are in fact from the community and responsible to the community. In the largest LHIN like this, every small community should have an advisory committee that is an integral part of the whole system, that is involved in all of the discussion, so that the community is involved all the way through. The funding has to come from the province somewhere along the line, but once the bulk funding is there, then the distribution of it should be done with a very major consultation process that involves not just the health care providers, but also the users and just general members of the community who want to see good health care provided in their communities.

The Chair: Thank you. Mr. Fonseca.

Mr. Fonseca: The local health integration system is really about the sustainability of our health care system. I have to say that I'm very excited about this particular

LHIN, the Champlain district, because the CEO of this LHIN was the medical officer of health, Robert Cushman, and he's done great work in terms of public health, population health, your anti-smoking or stop smoking initiatives here in this area.

Being the parliamentary assistant to the Minister of Health Promotion, Jim Watson, who was the mayor of Ottawa, I have to say that these are the type of initiatives that we need. I know that somebody like Rob Cushman here in this LHIN will be able to provide those best practices that are happening here and take those so that in Thunder Bay or in Toronto or in North Bay, they will also be able to adopt those practices. So that is what we are looking at, because part of the sustainability of our health care system is to really keep people healthy before they get sick, and that's where health promotion comes in.

I know that my colleague Kathleen also just wanted to mention a few things.

Ms. Wynne: I just wanted to thank you very much. On the issue of public engagement, community engagement, as opposed to "consultation" or "participation", the words that you used, the reason we've used "engagement" is that it could involve both of those, participation and consultation. I know that in some areas of the province already, there's work being done on what kinds of public engagement or community engagement should take place. So if you have specific suggestions about the kinds of things you think need to happen, that would be great, but the reason we've used the word "engagement" is that it's going to mean a variety of things in the different parts of the province.

Ms. Podolsky: But I think we would really like to see this written into the bill. If it's not in the bill, it doesn't get done. If somebody loses an election, chaos results.

Ms. Wynne: You want some specificity, and I hear what you're saying. Certainly I understand that that's something that we need to look at, but I think that we also have to be careful that we don't constrain what we mean by "public engagement," by "community engagement," because it's not going to look the same in every part of the province. So that's the balance we have to strike: being specific enough but not constraining people by outlining exactly what they should do.

Ms. Wilkinson: Our worry is that there's no requirement to really have it done at all. Our view is that the LHIN itself is really a small bureaucracy of the Ministry of Health. It is not a community group. If you then say that is a decentralization of the Ministry of Health into smaller areas, then underneath that you have to have the whole system that involves the public. That's what we see missing.

The Chair: Thank you, ladies, very much for your presentation.

PATTY PLAETSCHKE

The Chair: The next presentation is from Patty Plaetschke. You are from CUPE Local 1559?

Ms. Patty Plaetschke: That's correct.

The Chair: You can start any time you're ready.

Ms. Plaetschke: My name is Patty Plaetschke and I am 36 years old. I'm here on behalf of CUPE Local 1559, and I hold the recording secretary position in the union. I live in Athens, Ontario, a small town with a population of 1,000 people. The closest town to me is Brockville. Brockville General is my closest hospital, and in the last three years, it has had a huge renovation done to the facility.

I'm going to first tell you about a situation I found myself in; this was at least eight years ago now. I get kidney stones, and the first one I had actually got stuck in the tract from my kidneys and wouldn't move. My left kidney was twice its normal size before I realized that something was wrong. There is a process that involves a sonar pulse machine. It's a lithotripsy procedure whereby it pulverizes the stone with sonar pulses to break it up and get it moving.

At the time I needed this procedure, there was no such machine in Ottawa, where I lived at the time, and I had to go to the London hospital. I got no compensation, because I did not live in the northern part of Ontario, and therefore had to foot the whole bill. Along the way, my car broke down, and I needed to rent a car to get to London. Once I was there, I had to wait for my procedure because I had a fever by the time I got there.

The rest of the story is that I had to choose at that time whether to stay for the procedure or leave and wait with my kidney twice the size it should be and come back again when they had the next available time. I decided to wait overnight, and I was lucky enough that someone missed their appointment the following morning.

Once again, I had to foot the whole bill to get down to London, six hours away from where I lived, to get a procedure done, and there was no compensation for me. I can't imagine being 65 or 70 years old and having to go this far to get a procedure done. Even an hour away would have been uncomfortable. I was lucky enough and I was young enough that I had enough money to cover a rental, but when you're on a fixed income and disabled, where does that come from?

1520

There's now a machine in Ottawa, after the fund-raising was done by the hospital to get the machine. It then took the government another two years to say, "Yes, we will finally pay for the machine to be put into operation." I'm really afraid that this is what's going to happen after hearing the LHINs interview that the minister made.

I work for the Access Centre for Community Care in Lanark, Leeds and Grenville and have been there for the last six years, in the position of an accounting clerk at the moment. At this time, I wish to read to you the CCAC mission statement and values, and ask that you pay close attention to this, as I think this will point out some major issues that need to be addressed in the LHINs.

Their mission is: "To provide information, referral, access and coordination of services in partnership with other health and social service organizations in the

community to improve and maintain health, independence and quality of life for people of all ages."

The values: "In all our actions with clients, caregivers, staff, providers, volunteers, partners and the community, we will be:

"—fair and equitable in the provision of timely and consistent service;

"—respectful of individuals and supportive of their right to make choices"; I see the LHINs taking choices away from people in the homes;

"—sensitive to the rural nature and diversity of the community we serve"; I haven't heard until this last week of any community involvement in the decisions for the LHINs;

"—open and honest in all communications while ensuring confidentiality"; a big part of the LHINs right now is saying that they're going to enhance the system of the access centres, and they don't tell us how;

"—responsible and accountable"; if we can't get accountability within the LHINs act, how can we be responsible and accountable to our clients as well?

"—committed to excellence and continuous improvement;

"—active in encouraging learning opportunities; and

"—active in enhancing community partnerships."

I will now tell you what I experienced and what I have witnessed while working at the access centre. In the beginning, the CCAC's role in the community was to assist hospitals from having people stay to recuperate, and to prevent people from being admitted to nursing or retirement homes, because there were not enough spaces available to accommodate everybody.

In the beginning, I also got to see what the access centre did in the community when it came to nursing and therapy in people's homes. It was very satisfying to be working in a place like this. After a while, I realized what the homemaking aspect of our service did for our clients and the effects we had on their lives. We would go into the home and help these people to bathe, and clean their living quarters enough that they could still entertain people and feel good about themselves. We would assist in making meals and in doing the everyday things that are easy that we all take for granted, like grocery shopping and banking.

These people were able to stay in the community and feel that they were still living a normal life, and in response, they were healthier. They were less likely to need to be placed in nursing homes, long-term-care facilities and retirement homes. They had their dignity and pride and still felt they were in control of their lives. They could choose for themselves how they wished to live. On top of all this, we had a relationship built between the caregiver and the client that is unlike any other relationship.

Once the bidding process was started within the CCAC, we saw a freeze on funding as well. We were given the same amount of money but had increased numbers of clients. We were being used more than ever by the hospitals for recuperations at home. The money could only go so far, and something had to give. The

homemaking was then reduced, and people managed to get by with less housework and perhaps used more of the Meals on Wheels program.

The following year, our funding was still not increased and our client numbers still went up. The homemaking was then stopped altogether, and this is where I think what the government did was reprehensible, cold and callous. We first show these people how we can help keep them in their homes, and then slowly take that right away from them. They stop having friends and family over due to the lack of housekeeping, and they feel less like a part of society that is valued. We strip them of their dignity because we now say that they can only get help with a bath if they need us for some other service, like nursing or therapy to recuperate from an injury.

Eventually, the worst occurs, and it is discovered that these people cannot stay in their homes and keep the life they created because we are not there to help them prepare meals. They become frail and are susceptible to infection and colds, thus causing the reverse of what we set out to do. We take away these people's self-worth, because now they once again are looking for placement in facilities to help them survive. Even worse yet, I believe that in a few cases this has caused earlier deaths.

I find it very hard to believe that the executives and the service providers in this industry associated with the CCACs did not try to voice their concerns and prove to the government that what was being done was causing such damage in the community. It appears the health minister and the government were not listening, as far as I'm concerned.

First, we need to know what role the CCAC will have in the future with the LHINs. The minister continues to state that the CCACs will have an enhanced role in the community. I wonder, with all the cutbacks and closures in the mental health industry, is there a proposed plan to add this to the CCAC blanket of health and, if so, is this the minister's way of opening up the bidding process in the mental health realm? They have done all the damage they can do in the home care sector; now let's see what can be done in mental health.

What weighs on my mind the most is the regional boundaries of the LHINs and the fact that they are not conducive to open speech about specific communities and the problems they face. As a taxpaying citizen, I want to see changes to this bill which will ensure that we get heard, that services can stay local, and that the people who pay for the service can get the service needed, which is our right, and not suffer a hardship to get that service.

I want to see changes to this legislation which will protect our local services and access to care. Our support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability will make it easier for governments to implement these threats.

I want to see provided in the bill that cabinet, the minister and the LHINs may only exercise their powers in the public interest, with "public interest" defined to include preservation of the public, not-for-profit character of our health care funding and delivery system.

—Provide in the bill that the LHINs, the minister and the cabinet cannot order direct integration nor approve/disapprove integration. The power the LHINs have to withhold funding is power enough to encourage consolidations. The LHIN, minister and cabinet should not have the right to transform the health care system unilaterally; otherwise, there is no reality to the claim that we are enhancing local decision-making and no point in retaining provider governance structures.

—Provide in the bill that the LHIN, ministerial or cabinet power to withhold funding to force integration only be exercised where necessary in the public interest and where integrated services remain publicly delivered on a not-for-profit basis.

—Provide in the bill that transportation subsidies will be paid by LHINs if the required service is no longer provided in a given community. No purpose is served if integration creates new costs for residents.

—Provide in the bill that nothing in the legislation authorizes cabinet, the minister or LHINs to override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements. As you know, I am with the union.

—LHINs should be required by the bill to do an annual survey of unmet needs and to report unmet needs in annual reports to their communities.

Of course, this is all my personal opinion and what I see from the position I hold within this community.

The Chair: Thank you. There is only one minute left, so why don't we take 30 seconds each. I'll start with Madame Martel.

Ms. Martel: Thank you for making a presentation today. I've already said what I have to say about competitive bidding in home care. What's interesting is that two of the basic changes that could be made that would give more home care to more clients, which the LHINs have absolutely no control over, would be to get rid of the current regulation that limits the amount of home care a client can receive and, secondly, get rid of the regulation that says you have to have a basic care need, a bathing need, in order to get homemaking services. While the minister says this is about service as close to home as possible, those two regulation changes are solely within the power of the government, and the LHINs have nothing to do about them. If you made those changes, more clients would actually get the care they need.

Given what you've seen with respect to competitive bidding, when you think about the possibility—because it's not explicitly forbidden in the bill—that this could be expanded to other sectors, where do you think this is going to lead, not just for workers like yourself in the sector but for the clients who need those services?

1530

Ms. Plaetschke: We of course see a lot of palliative care and long-term care, but mainly in the palliative, these people don't want eight or nine different service-providers coming in in the last few days of someone's life. That's the last thing they want to see: total strangers, time and time again, having to learn their whole medical

situation before they leave. With the competitive bidding part of it through the access centre, that's exactly what's happening. We remove these people's right to privacy, basically, because so many people come in to deal with this person in the last few days of their life. I don't want that to happen when I go to a hospital, that I have to go from one hospital to another and to another to finally get the service I need because it's not offered, even though at one time it might have been in my local hospital. That's my worry.

Mr. Leal: Patty, thanks very much for your presentation. I have two quick questions. First, when you talked about the regional disparities and people having to travel to other areas, it seems to me, and I'll get you to comment, that one of the goals of LHINs is to reduce those travelling disparities and regional disparities, to get treatment closer to home.

Ms. Plaetschke: But how do you do that when the LHINs have places in our region now that I've never even heard of?

Mr. Leal: They're going to be doing planning for the local area.

My second question. I forget what page it is, but in your brief you say, "I've heard questionable things about the people appointed to LHINs already"—

Ms. Plaetschke: I didn't read that, and I'd actually like to remove that from there.

Mr. Leal: Oh, you would? I was going to ask you a question: Did you check the facts or did you just put that in there?

Ms. Plaetschke: As I say, I've only heard little bits, so that's why I chose not to read it.

Mr. Leal: I appreciate that you removed it from your formal presentation.

Mr. Wilson: I should probably know this, as labour critic for my party, but perhaps you, Helen or Doug could tell me: Are all the CCACs unionized?

Ms. Plaetschke: Yes, they are, I believe, in some shape or form. If it's not CUPE, it's ONA or OPSEU.

Mr. Wilson: Does CUPE have a majority, or do you know how it breaks down?

Ms. Plaetschke: No, I think it's ONA more than CUPE, because they have to have a degree in nursing or therapy to work as a case manager within the offices. In some access centres, the positions are not always clearly defined. Some are through the health units and some are with the access centre, depending on how they split up the access centre and health unit back in 1999 or 2000 or 2001 or something like that.

Mr. Wilson: And the people who actually deliver the services are really scattered.

Ms. Plaetschke: Yes, and those are through the outside agencies, which are done through the bidding process now. Those poor people, as you'll hear from my colleague from the access centre a little later on this afternoon about the bidding—you'll find what's going on at that end from her.

The Chair: Thank you for your presentation.

KINGSTON MUNICIPAL SUPPORT GROUP

The Chair: The next presentation will be by tele-conference. Do we have Matthew Gventer? You have the line, sir.

Mr. Matthew Gventer: Thank you so much for letting me appear. I am speaking on behalf of a group of citizens of Kingston who have worked together to increase the voice of citizens in the municipal affairs of our city. I do not claim that we have a great deal of special knowledge or insight into the workings of our health care system. We do bring to this committee our insight into the development of community and the importance of community input into the planning of any service to be delivered to that community.

I spent many years working with First Nations people in our federal prisons. I spent many hours listening to native elders provide counselling and guidance. Often, they spoke at great length with intriguing stories that seemed unrelated to what we were considering. What was overwhelmingly evident at the end was how profound their messages were and how relevant and effective their communication was. I hope you'll be similarly patient with me and what I have to say, and similarly rewarded.

To illustrate the points I will be making, consider the analogous example: In our city there's currently an issue working its way through city council. City council has voted to build the central ice skating multiplex in the outskirts of the city. To avoid competition with ice space available elsewhere in the city, the original proposal was to close three neighbourhood rinks. What is driving this proposal is the bottom line, financially. It is intended that outside tournaments be drawn to the multiplex, which will help finance the facility. It will be a state-of-the-art facility. The proposal was closely monitored by the public and by an advisory body attached to the committee deliberating this proposal. Evidence was presented to show that important neighbourhood functions, especially in a less-advantaged district of our city, would suffer if they closed the neighbourhood rinks. It was learned that children and others used the rinks for general recreation to a larger extent than occurred at other rinks. This has led the city council to delay the decision to close the existing neighbourhood rinks.

It is this capacity for a community to mobilize its resources and bring pressure and information to bear on a decision that is being denied in the LHINs legislation. We know enough about the past dynamics of structural change in the health care system to know from where this policy is coming.

The Ministry of Health has been frustrated by being thwarted in its intentions in the past. This is certainly very evident in the process of restructuring health care in Kingston. The Duncan Sinclair hospital restructuring commission recommended the integration of all hospitals in Kingston and the closing of the Hotel Dieu hospital. This intention stirred great resistance, including from our MPP, John Gerretsen, which forced the reconsideration of that decision. Hotel Dieu remains open and is oper-

ating in a totally co-operative and functional way with the other hospitals in Kingston.

We want the legislation changed so that communities have the right to appeal decisions of the local LHIN; that there are announcements well in advance of decisions so the public can have the opportunity to learn of changes that will impact on their communities and so they will have time to react; and that the evidence justifying the change be made public so the communities can refute or accept the changes.

I carefully reviewed Bill 36. I agree that I'm not a legal expert and that much of the language is hard to penetrate; however, it is clear to me, it seems, that the legislation claims to be responsive to local communities. It has promised that community consultation will be built into the development of strategic plans. What also seems clear to me is the exclusion of the community from what are questionably called "integration decisions." Decisions will be available at the head office. Only parties to agreements will be allowed to appeal decisions, and the community is not considered a party to a decision. The appeal period will be limited to 30 days.

I once chaired a Kingston social planning council committee called the Planning for People project. We would receive announcements of intended zoning and city plan changes. We'd then have the chance to survey the neighbours affected and find out how they viewed the changes. Sometimes the reactions were very strong and hostile, and people reacted by organizing themselves to address the proposals. In most of these cases, changes were implemented in the proposals that made the development more acceptable to the neighbours. Larger fences were built or uses were restricted slightly or plans were downsized a bit; access routes might be ensured. On occasion, the neighbours were able to resist the most imposing changes. What may surprise you is the frequency of neighbours saying that the changes were reasonable. In one case, I remember the neighbours all saying that the business asking for the changes had been an excellent neighbour and they totally trusted the business to take the promised action to avoid intruding into the residential neighbourhood.

The committee of the Planning for People project was resented by the planning board and the developers and lost its function when the privilege of advance notice was withdrawn. This was a significant loss to the community and to the planning process.

I'm asking your committee to show more maturity and more trust in the public. Don't exclude the community from the process. Don't fear transparency and accountability to the community. We are not customers, as our city likes to call us when we phone in to city hall; we are citizens and taxpayers. I treasure the years when the political parties espoused citizen involvement at every stage. In fact, it wasn't so long ago when the Liberal Party considered this to be a foundation of its policies. The Reform Party identified itself as a grassroots movement. The NDP continues to claim citizen participation to be essential to its identity. Parties in the last provincial

election ran on a platform of open government and full public disclosure.

I've given some examples of the value of meaningful community participation. Now allow me to remind you of examples of communities suffering from the kind of top-down decision-making envisioned in this legislation. I turn to two examples of CCAC decisions regarding Kingston health care deliveries.

Hospice Kingston lost palliative home care contracts in 2002. Ten nurses were laid off. These nurses were leading practitioners of palliative care and care for the dying. They were vital parts of the service program of Hospice Kingston. Hospice Kingston was and remains more than a source of clinical home care services. It provides respite care and a residential sanctuary when needed. It coordinates hundreds of hours of volunteer support services for the sick and dying. At that time, it helped families with bereavement services. What a heartless and thoughtless decision was the withdrawal of funding for home care nurses from Hospice Kingston. It left the organization with a debt of \$250,000. It forced the sale of a respite facility. It forced the cessation of the bereavement services.

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The survival of Hospice Kingston is a tribute to the dedication and spirit of the Kingston community. One has to wonder how a CCAC board would have made that decision if it looked at the larger role of Hospice Kingston. I remember meeting one of the lead nurses of Hospice Kingston after the loss of the service. She had been a leading figure in the development of palliative care service in Kingston. She had been the leader in the development of palliative care clinical nursing in Kingston. Now she was left with her career suspended. I remember so well her expression of consternation over the fact that she had been asked to provide training for the successor company. Isn't it ironic that the chair of the southeastern Ontario LHIN was president of the successor company, a private home care company, All-Care Health Services?

Another sad case of undermining the charitable spirit of our community was the transfer of home care service from the VON Kingston to another organization. Not only were full-time salaried nurses turned into casual labourers without benefits, but the CCAC had to disregard the support role that the VON plays as sponsors of Meals on Wheels and other community maintenance services. You don't disrupt the stability of an organization like the VON without challenging the integrity of the community.

Clearly, the health care community is more than just a bottom line. It is a coherent, organic whole. Decisions need to reflect the organic community. Providing for community representation and decision-making and community input into decision-making is critical to the process.

Allow me to digress just slightly. I want to put a human face on the instability created by the picking and choosing of who will do what from year to year. This may not be an outright bidding system yet, but the legislation implies it and certainly involves a radical moving

of services in and out of organizations and communities. I was canvassing for a political party a few weeks ago. I knocked on the door of a basement apartment in a lower-market-rent apartment building. The door opened and a middle-aged woman answered, thin and dressed in a low-cost housedress. She was dismayed to see a politico at her door. Almost in tears, she confronted me with her experience as a home care worker. Standing in the doorway, I could see that this woman was living in an apartment furnished with what could well have been Salvation Army seconds. Be assured that the apartment was clean, neat as a pin, and so was she. She was not a disorganized, poorly functioning individual. She related her experiences as a home care worker. A dedicated worker who cared deeply for her patients, she had not been employed by one employer for more than six months at a time. Denied benefits, denied secure employment, she was forced to work as a casual and accept assignments on an on-call basis. Her pay was dismal. She had to find the means to get to her patients at her own cost. What could I do for her, she asked. If my candidate had been elected, you can be sure people like her would have been at the top of our agenda. Instead, it is up to you to act on her behalf.

Bill 36 is an extension of the CCAC system. It needs to be rethought. You have the power to redirect the process. We are all counting on you to do that.

If I had the time, I would have discussed another matter in depth: the power of the minister to redirect charitable property to any health care body, non-profit or for-profit. I consider this to be a travesty. It should be reconsidered. In preparing for this presentation, I researched an extensive, albeit partial, list of charitable donations delivered by the community to hospitals and health organizations in our local communities. The goodwill should not be abused and disrespected by diverting them out of the community that donated them and out of charitable organizations.

For example, I quote from a recent letter in the Kingston Whig-Standard from the chair of the Hotel Dieu and Kingston General Hospital foundations:

"You may be surprised to learn that only about 5% of the total number of children served by KGH and Hotel Dieu must go to Ottawa or Toronto for medical and surgical treatments. This number is so low because our hospitals are able to provide highly specialized, world-class paediatric care to children in our region. The government doesn't provide all of the funding needed for the outstanding paediatric health care we provide, so we must look to our community for help," and they went on to describe the extensive funding that was provided by public charitable donations.

I spoke to a CEO of one of our local hospitals about this issue. He was not concerned. His view was that the ministry wouldn't be so stupid or irresponsible as to close or privatize a local hospital. If it is stupid and irresponsible to move charitable resources into private, non-charitable hands, why include that unfettered power to do so in the legislation?

Thank you for listening to me. I was a bit emotional, but there's a lot of feeling in this.

The Chair: Thank you, Mr. Gventer. You've used the 15 minutes total, so we thank you for your presentation. Have a nice evening.

The next presentation is from the Elementary Teachers' Federation of Ontario, ETFO, Limestone local, Kingston and area. Is anyone here from that group? There's not.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2875

The Chair: We'll move to the next one, which is the Canadian Union of Public Employees, Local 2875, Ottawa. You can start any time you're ready.

Ms. Roseanne Dean: Thank you. My name is Roseanne Dean. I'm a registered practical nurse and also the president of CUPE Local 2875 at the Queensway Carleton Hospital. I have Doug Allan and Joy Stevens with me.

Once again, the Ontario government wants to transform health care and certain social services, this time by creating local health integration networks, or LHINs. Fourteen LHINs have been established in the past year to plan, integrate and fund hospitals, nursing homes, homes for the aged, home care, addiction, child treatment, community support and mental health services. Ambulances and public health services have been, as health and long-term care minister George Smitherman says, initially excluded, along with privatized labs and clinics. The government has also allowed doctors to escape the LHINs. If passed, Bill 36 will give the government and LHINs new and troubling powers to restructure public health care and social services.

The LHINs are local in name only. The bill would grant little real power to local communities and providers to make decisions. Rather, it transfers control over local community-based providers to the minister and cabinet and to their agents, thereby centralizing, rather than localizing, control over health care and certain social services in Ontario. The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

The government describes the legislation as a made-in-Ontario solution that would give power to the local level. In fact, the government's reform takes the worst aspect of health care rationalization in other provinces and combines it with the worst aspects of health restructuring in England. It would create a new layer of bureaucracy and would be unaccountable to local communities.

The LHINs cover vast and diverse areas. The LHIN boundaries have been formed based on the hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent community interests.

The Champlain LHIN covers the area from Mattawa to Brockville, with a large rural community stretching from end to end, where patients would have to drive long distances and many hours for medical services. The large socially diverse areas covered by the Champlain LHIN also suggest that there will be significant conflict over resource allocation.

What services will the LHINs provide in each area of the LHINs? Unlike government, LHINs will not be able to increase revenue. The smaller communities may be the first to see their services integrated into other communities. The government will control the LHINs' funding and each LHIN will be required to sign an accountability agreement with the government.

1550

LHIN boards will be responsible to the provincial government, rather than local communities. This is in contrast with the long history of health care and social services organizations in Ontario, which as a rule are not appointed by the provincial government.

A key goal of this reform is to constrain costs by integrating services, but this also raises questions about cutting services in local communities. At first, the government talked only of the integration of support services. Cutting back services is dangerous and inefficient. It often requires more highly paid and trained staff to take over the functions formerly done by hospital staff. Hospital-acquired infections already kill thousands in Canada every year.

The government plans to regionalize hospital support services. The Champlain LHIN is already exploring the possibility of a supply chain and an IT system to connect the Champlain LHINs. In the Champlain LHIN, where distances are particularly large, this could add a lot of travel.

Clinical services are threatened, and in the Champlain LHIN, patients will be forced to drive up to a few hours, and sometimes more, for services, as some are already doing for birthing services. Even where distances are measured in driving many kilometres, specialization creates special problems. Instead of being able to deal with their problems at one centre, health care services will be spread over many health care providers, creating a real problem for those with multiple health issues, especially the elderly and poor families.

The government has also begun to move surgeries right out of hospitals and place them in clinics. The first instance was the recent creation of the Kensington eye clinic. This clinic, previously at the recently closed Doctors Hospital in Toronto, is supposed to move 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries. This, the minister says, is only the beginning.

The creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to, as they tend to their health care needs. It also raises the possibility of the establishment of for-profit clinics.

The man behind Canada's first privately owned clinic is setting his sights on Ottawa, which is in the Champlain

LHIN. He intends to open an 11,000-square-foot health diagnostic and physiotherapy centre without long waits. Patients would pay an enrolment fee of \$1,200 and an annual basic charge of \$2,300. The \$2,300 basically covers the medical plan.

Private health care undermines the public system. It will do more harm than good as it takes medical personnel out of the medical system. When you take patients out of the public system, you also take caregivers out of the public system. Universal access to health care is a cherished social program. Private centres provide service for basic ailments and refer patients back into the public system for more complicated matters. That is the cream-skimming part of the operation. They earn the big bucks and leave the high-cost stuff to the public health care system.

This change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act of 1997 to many potential changes in employment that could result. CUPE is closely examining the impact that Bill 36 and its use in some cases of the Public Sector Labour Relations Transition Act to deal with the labour relations issues raised. We are concerned that the Public Sector Labour Relations Transition Act may not be applicable in cases where the entity receiving the work is not a health service provider and where the primary function of the entity is not the provision of services within the health care sector. This may allow LHINs or the government to transfer work without providing health care workers the right to a union representation vote. We would like to make it crystal clear that the employment security protections in our collective agreements cannot be overridden by this bill.

Because of these concerns, we believe that this bill and the government's attempt to restructure health care need to be rethought. We have made some suggestions for how health care reform could unfold. We urge the government to take a considered and consultative approach.

We'd like to thank the committee for listening to our concerns and suggestions.

Respectfully submitted, Roseanne Dean.

Ms. Joy Stevens: Good afternoon, honoured members. My name is Joy Stevens. I'm a registered nurse and I have a PhD. in ethics. I work in the area of community mental health outreach and addictions. The topics I address today have to do with how Bill 36 affects and impacts these areas.

I am troubled to see that community mental health outreach and addictions are not specified in the act at all. I will begin with a discussion, briefly, of the strategic plan. I understand that the integrated health service plan needs to be consistent with the ministerial plan. To accomplish this, the LHIN is expected to engage the community. I have some concerns about that because I believe that the structure actually creates barriers to local

community control. There's no ministerial obligation to fully consult the community prior to imposing the accountability agreements, and this is troubling. We need to define what we mean by "community" and "community engagement" and "decision-making at the community level."

Since community mental health and addictions are not mentioned in the act, these are areas in which there is a need for consultation with the affected communities. We need just representation of the health sector employees and other health professionals on the advisory committees that are mentioned in subsection 16(2) of the act. I remind you that public interest arises whenever the aims of quality improvement and fiscal responsibility in public health are considered together.

My second point is on the funding model. We do not know exactly what the funding model is going to be like. We do not know how funding to, say, heart disease or schizophrenia is going to be allotted. As the act, again, is silent about community mental health and addiction services, I urge you to set aside protected funding for these services. In other words, the local health integration networks need to be adequately resourced to fulfill the important mandate of these community services. I want to remind you again that these are preventive services, preventive strategies, because they not only improve the quality of life in the community—and I've seen that—but they respond to the importance of economic efficiency in reduced hospitalizations.

On the boundaries, the vast area that's covered by the LHIN boundaries cannot represent local community interests. With government control from the ministry level to the board level, and with pre-existing accountability agreements, we're concerned that funding can be flatlined or reduced. The boundaries of expansion for health services are increased, but secretive budget cuts can be, and have already been, the case. Since community mental health and addiction services are, again, not specified, we're concerned about protections.

At my workplace, we've already lost an important service through the cutting back of the extended hours team. The extended hours team used to work until 12 midnight seven days a week. These services were cut to 8 p.m. With mental health patients, this is a concern. What happens is, the clients are left with seriously unresolved issues. They're left to wait till morning. This is very difficult for people with severe mental illness and addictions. In the morning, community support workers take up the slack, and then their clients, who are seen on an appointment basis, are the ones who suffer and have to wait longer. I've seen the results of this in clients who react with anxiety, helplessness, paranoia, anger and many acting-out behaviours. So in this sense, the system makes them sick.

Number 4, the not-for-profit character of community mental health and addiction services is under threat, and this is quite a concern. We know that privatization is a buzzword for seizing profits. Instead of integrating a service, please know that the competitive bidding process

will fragment it. It will leave it vulnerable to cheaply acquired and often lower-quality service provisions.

Please remember that in community mental health and addiction work, relationships of trust with clients are vital, and these take many months or years to establish. Quality engagement holistically involves levels of multiple domains that include psych care, physical health care, legal issues, housing advocacy—many of our clients are homeless—and spirituality, to name only a few. Purchaser-vendor agreements have the potential to shatter these therapeutic relationships and to cause harm. I'm really concerned about that. As I say, relationships of trust are so vital in this work.

In addition, in community mental health and addictions we're not tightly organized with language in collective agreements to provide employment security, so I do urge you to take care to protect working conditions, bargaining rights and employment guarantees, which are respected by all parties to a purchaser-vendor contract. I remind you, too, that the terms of collective agreements are devised by persons who are involved in and who are most knowledgeable about the nature of the work they do. Thus, collective agreements affecting the work conditions and lives of devoted outreach professionals must not be overridden by Bill 36, and I do urge you to clearly stipulate this in the act.

1600

Finally, free enterprise in a health care system: The basic premise of Bill 36 is equal access to health care, and the vehicle for accomplishing this is integration of services in purchaser-vendor agreements. The values that govern free enterprise and those governing delivery of health services very often conflict. That's because the economic rationalist aim and the aim of optimum health care for each member of a community entail different responsibilities. The former system is geared toward efficiency and profit, and the health care system is based on optimizing the health of all community members, and this is a common good. Decisions about health care are substantively different from business decisions. Furthermore, the values that are given priority in any decision will differ among people according to your beliefs, your experience and your professional background. The omission of community mental health and addictions in the wording of the act speaks directly to the values and aims of the architects of this act, and that's troubling.

Who makes what decision is critically important, keeping in mind that health care decision-making affects all of us. So I'm asking you: What kind of ethical framework was applied in the design of Bill 36? I suggest that every decision needs to be vetted by an ethics committee which is made up of persons with training in ethics—unbiased professionals who can clarify ethical boundaries, who can identify unsound and unfair proposals and who can help to formulate an example of ethics-based health care legislation. Thank you.

The Vice-Chair (Mr. Khalil Ramal): Thank you for your presentation. Your time is over; you used your 15 minutes. There is no time for questions. Thank you.

OTTAWA RAGING GRANNIES

The Vice-Chair: Now we have a second group with us: the Ottawa Raging Grannies.

Ms. Pat Howard: We're going to sing you one verse of a song, and then—

The Vice-Chair: Excuse me, before you start, can you mention your names, if you don't mind, for the record?

Ms. Ria Heynen: My name is Ria Heynen.

Ms. Peggy Land: My name is Peggy Land.

Ms. Joanne Bennett: Joanne Bennett.

Ms. Howard: Pat Howard.

Ms. Jeannette Pole: Jeannette Pole.

The Vice-Chair: Go ahead.

Ms. Howard: Later we'll treat you to the rest of the song.

L-H-I-N-S—more bureaucracy

What would Bill 36 do for you and me?

Centralize services, less democracy

Too much power in the hands of one ministry.

Ms. Land: There's more to come. Thank you for this opportunity. I'd like to share some of my own experiences within the health-service-providing community in which I have been working for many years. I would like to emphasize that these are my experiences; I don't speak for my profession. But I have been working for 35 years as a physiotherapist and have witnessed the steady erosion of public accessibility to health care under OHIP, especially for physiotherapy. Sometimes I'm also a Raging Granny, and I'm pleased to be here to speak for those women especially who are vulnerable and in need of quality health care.

The concept of locally-integrated health care is a good one, but if such services are to be contracted out under an LHIN umbrella, then I foresee serious problems with this plan and that it can only deliver results that are very inferior to the current system of medicare and hospital-based services.

In the 1960s, all physio was provided through OHIP in hospitals. Some of you will remember this. People got the treatment they needed. Therapists provided the care that was needed. We were all paid salaries, not per-patient visit. There was no conflict of interest, because there was no profit to be made. There were no privately—or combination private-public—funded clinics. Then OHIP paid some private clinic owners to provide additional outpatient physio, and the physios were paid by the visit, in part through OHIP and in part by the patient. This is where things started to go really wrong. We were not paid very much, had no job security and no benefits, and often had to see more people per hour than we were used to seeing in hospitals. Two per hour for outpatients is adequate, but four is assembly line. If you've ever experienced being one in four people being seen in an hour by a physiotherapist, you'll know what I mean. Sometimes it was, and still is, worse than four per hour, depending on the amount paid per therapist and the pressure placed by clinic owners. We found that, gener-

ally, when visit time is shortened it takes more visits to get people better. It's that simple. But more visits paid more money, and of course there was a conflict.

Clinic owners had sold their businesses for escalating amounts until it was not uncommon to pay at least \$1 million for such a little gold mine, but the costs only got passed on to those patients who could pay to avoid longer waits in ever-shrinking outpatient clinics in hospitals which were being steadily underfunded themselves.

This situation has not gone away and threatens now to be instituted in LHINs, in my opinion. The clinic situation has continued to worsen. When clinic owners found out that physio could be mostly covered by extended health insurance plans for some, they could charge more per visit. This was supposed to mean that the physios could be paid more and thus see fewer patients per hour. But, given the escalating costs of rent, equipment and office staff, and that physios were hired as independent contractors, not by the hour, the temptation was, and is, to pressure the therapists to see more than two patients per hour. Again, the patients were, and are, the losers because no matter how much they pay they are often rushed through, given insufficient time per treatment, and limited by their own insurance coverage in number of visits as well.

A growing number of privately owned clinics are now actually part of larger chains. Physio has become franchised and very competitive. Not all, but some, are parts of franchises. Some clinic owners are getting rich in the process, but it is not uncommon for therapists to have two or three part-time jobs, all insecure and not well-paying. Two years ago, the hospital outpatient clinic I was working in was closed down because of underfunding. But about 85% of its costs were for salaries of staff; the space and equipment were already owned. So our expenses were very low and we offered a very good service—so good that some referring doctors told people to wait, that they would be better treated than in some private or semi-private clinics. Our waiting list was six months, and now it's up to two years for the only remaining open-access OHIP clinic in the city.

I have to apologize for some typos in my handout here; I wrote this on my lunch break.

Nonetheless, hospitals have become the employers of choice again because physios, speech and occupational therapists, dietitians, social workers, nurses and RPNs are unionized and—dare I say it—get fair salaries and, best of all, have no conflict of interest to deal with.

Under a system of contracting out, LHINs will never be attracting the best-qualified staff, because they will be working in hospitals. People want quality time with their health care providers, they want not to be treated as numbers, and they want timely treatment too. But real health care is about all of this, not just part, and it is not found in for-profit, conflicted situations which would be built into LHINs, which contract out.

I think it would be better just to put the money it will take to run LHINs right back into the not-for-profit hospitals and let them deliver the same services.

Meanwhile, what assurance can you give me that the LHIN plan does not include awarding contracts to the lowest bidders, and what assurance is there that bidding will not be restricted to even only Canadian-owned providers?

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In the same way that Wal-Mart practises predatory pricing, health care franchises and chains can set up business and offer cheaper prices initially, plus inferior service, until the competition is killed off, and then just raise their prices. How would LHINs prevent this from happening?

Of course, a growing population of aging baby boomers and the elderly, living longer but not necessarily better, has put enormous strain on the whole system. A sadly high proportion of the poorest are elderly women with no extended health care coverage, often living alone and becoming more and more vulnerable. They remind me every day that growing old is not for the faint of heart, and I agree.

How will LHINs provide better care for people, especially the frail and vulnerable, when they themselves—the LHINs—are inherently conflicted and unaccountable? I hope you'll seriously consider these concerns before jumping off what looks to me to be a springboard to contracted-out disaster.

Now we'd like to finish our song for you.

L-H-I-N-S—more bureaucracy

What would Bill 36 do for you and me?

Centralize services, less democracy

Too much power in the hands of one ministry.

This complicated bill.

The one they want to pass

It seems to us it will

Become a horse's ass.

The privates they would bid

On services we get

We're headed for the slippery slope

And through our safety net.

L-H-I-N-S—it's a horse's ass

It's plain to see

For you and me

It should never pass.

We'll just take note of how they vote

And notify their mothers

And then we'll all get down to work

Replace them with some others.

The Chair: Ladies, we do have a minute each. I think Mr. Wilson may want to continue the singing.

Ms. Heynen: I would like to say a few words before we finish. In the first place, please, the Raging Grannies are dead serious. As you heard, the Raging Grannies, although not claiming we are experts on the issue, have a deep distrust of Bill 36, which will create the local health integration networks. The legislation is so unclear, so

vague, it makes our old—but don't forget, still rather wise—heads spin.

One of our conclusions is that LHINs seem to give enormous power to the boards of directors of the 14 regions, which are appointed by the government. Public input, I think especially from the health care workers themselves, will be missing.

Since the Liberal government has been shown to favour the private sector in our health care system—I'm just thinking of the two P3 hospitals, and are there more to come; and what did they promise during the election?—what, then, are the instructions given to the LHINs? How can we know what our government is up to? It seems that all restrictions, as far as I can figure out, are off in regard to keeping our health care system public. Indeed, there seems to be no protection against for-profit privatization in this legislation.

The Grannies are shuddering at what LHINs might mean for our home care, for example, for psychiatric care, for our health care workers themselves and for our local services. This whole system could very well develop into a very costly, bureaucratic, unhealthy, competitive nightmare, not to mention the legal wrangling it will create.

To begin with, if this government wants to pursue it, then it is their duty to provide enough clear information on Bill 36 which every person here in Ontario can understand. The public has to know about and be fully involved in this radical restructuring of our health care system. Yes, the public has the democratic right to even reject Bill 36 and agree with what the Grannies sang:

L-H-I-N-S—it's a horse's ass

It's plain to see

For you and me

It should never pass.

Thank you very much.

The Chair: Down to 30 seconds each.

Mr. Wilson: Thank you very much, ladies. It was enjoyable. Of course, I'm in opposition, so I really liked your song. I'd just say thank you. A number of the points you made have been made before, but to have people with your seasoned experience come before us, we appreciate it.

Ms. Martel: Thank you very much for your presentation here this afternoon. Let me just say with respect to the very serious comments that were made regarding competitive bidding that if the government means what it says, that competitive bidding is not going to be used by the LHINs to acquire services, then they need to put that in the bill. Then we might all have some comfort that that is indeed the case, but because it isn't in the bill, you and every other group are right to come before this committee and raise your concerns with respect to this very important matter. Thank you for doing that today.

Ms. Wynne: Thank you very much. You are wonderful.

You used the word "centralization," and many groups have talked about their concerns about centralization.

How is taking \$21 billion and the responsibility for allocating and making a plan for the distribution of money and identifying gaps in a region—how is taking those responsibilities and putting them in the hands of a local health body like a LHIN centralization, when right now those powers and the control over that money sits in the ministry at Queen's Park, in the hands of the minister? How is it centralization to put that into the community? I'm supporting this. I'm happy to be doing this because I see it as a decentralization and a giving of control to local bodies.

Ms. Land: I spoke to the importance of funding our hospitals, and I just see this as the imposition of another structure that's going to make a whole lot more bureaucracy. It centralized in that it's from above; it's imposed. But people aren't necessarily asking for this; what they're asking for is better-funded hospital care through medicare. I think that's all we're really asking for.

The Chair: Thank you very much for your presentation and for answering the questions. Have a lovely balance of the day.

I'll go back to the Elementary Teachers' Federation of Ontario. Is someone now here? That deputation was to be at 3:45. Is someone here? That is the Elementary Teachers' Federation of Ontario, Limestone local, Kingston and area. There's nobody, so we'll move on to the next one.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 870

The Chair: The next presentation is the Canadian Union of Public Employees Local 870, from Ottawa. You can start any time you're ready, for 15 minutes in total, please.

Ms. Susan Arab: Thank you for the opportunity to present before your committee today. My name is Susan Arab; I'm the servicing representative for CUPE Local 870. Bonnie Soucie, the president of CUPE Local 870, who was originally slated to present today, is home sick with the flu.

I am speaking on behalf of Local 870, which represents approximately 600 workers at the Perley Rideau Veterans' Health Centre. This is a not-for-profit long-term-care facility here in Ottawa that provides services for both veterans and community members.

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There are many elements of Bill 36 that are extremely worrisome. From a union perspective, the impact that the LHINs will have on the health sector employees, their jobs, their salaries and their benefits, will likely be devastating. But Bill 36 hurts more than health care workers. It will hurt health care services, it will hurt the people who rely on those services, and it will hurt the individual communities where those health services are currently provided.

I want to focus on three areas where Bill 36 will both impact on services and devastate health care workers' jobs and livelihoods. First, I believe Bill 36 will foster the establishment of a competitive bidding model in the

provision of at least some health care services, and it's possible that Bill 36 will allow the establishment of a competitive bidding model that could reach eventually to encompass most health care services provided in Ontario.

Second, we're very concerned that Bill 36 will open up the health sector to widespread private, for-profit delivery of both clinical and non-clinical health care services. Certainly, as I will discuss below, a competitive bidding model has been known to foster commercial interests in the health care sector over non-profit community-based interests. Furthermore, the powers allocated under sections 28 and 33 of the act could easily result in the transfer of huge portions of our health care system from the not-for-profit agencies and organizations to for-profit commercial ventures that currently have little or no experience in the health care sector.

Finally, we have a concern with the fact that the act ensures that those who make decisions regarding health care, namely the LHINs, are virtually unaccountable to the affected public.

On competitive bidding: Bill 36 will create the conditions to establish competitive bidding among health care providers, not just in the home care sector, where it is currently being used to the detriment of home care clients and workers, but throughout the health care system. I'm sure that government members on this committee are likely to protest and say that nowhere in the legislation is a provision that establishes competitive bidding. However, a close reading of the legislation, in conjunction with the Minister of Health's own comments, indicates that competitive bidding will be the outcome of Bill 36.

If you look at sections 19 through 21 of the act, they stipulate that LHINs can fund health services on terms and conditions they consider appropriate. The act also stipulates that LHINs must allocate funding in keeping with the strategic plan of the Minister of Health. The Minister of Health has indicated that his plan for future health care funding is to set prices for hospital services on a service-by-service basis. Instead of global funding, hospital services will, in the future, be provided on a—dare I say it?—fee-for-service basis. The minister has already identified five clinical services that will be the first to be funded in this fashion: cataract surgery, hip and knee replacements, cancer care, MRIs and CAT scans. The amount of funding for each of these services will be set by the LHIN, and the LHIN will put out to tender who will provide these services from among the health care facilities.

The powers provided to LHINs under section 26 of the act will allow the LHIN to set the prices for the health procedures; set tenders, if they choose, among health care providers; move from global funding of health services to a fee-for-service model; and purchase a service. These are all key elements that can open the way to competitive bidding in the health care system that we have today.

Mr. Smitherman also indicated in his press conference and in interviews that other health and possibly even social services will follow on this model. This is extremely unfortunate, because the experience of com-

petitive bidding in Ontario home health care has been devastating for health care workers and their clients. As you know, the Conservative government introduced competitive bidding in community-based health care in 1995. Agencies got to bid on a three-year contract. They also cut beds in the hospital sector, arguing that they could move those services to the community. What happened as a result in the home care sector was that stability vanished. Long-standing not-for-profit community agencies have either gone bankrupt, have closed or have been severely decimated. The VON in Kingston is closed; the VON in Hamilton is gone. Visiting Homemakers in Ottawa was devastated by cuts two years ago when they lost their CCAC contract. Years and years of agency experience and history in community home health care has been wiped out in under a decade. Instead, we have large commercial health care corporations with no connection to the community they serve. The most reliable figures show that the percentage of home care nursing market share provided by for-profit corporations has increased from 18% in 1995 to 48% in 2001.

So for health care staff providing home care, it was and is a race to the bottom. Agencies that won CCAC contracts cut labour costs to win the tender. Staff lost their modestly paying full-time jobs. They found less-well-paying part-time jobs. Turnover of staff was and continues to be huge. Home care clients suffer from the lack of continuity of care.

Dr. Jane Aronson is a professor of social work at McMaster University and has spent the last several years studying the effects of competitive bidding on women in the home health care sector, both the women clients and the women health care workers. In an interview with the Ontario council of hospital workers she described the insanity of competitive bidding. If you'll indulge me, I just want to quote this. It's a long quote but it's quite interesting.

"The organization and the home care workers who I followed here in Hamilton experienced this cutting and demoralizing process in the early years of managed competition. But then in 2002, when the rationing of supportive home care became more pronounced and more clear as a central injunction to CCACs, the demand for home support services in this community and other communities all over Ontario started to plummet very suddenly. And non-profit organizations like VHA couldn't accommodate it because they had infrastructure, they had unionized employees, so they couldn't start asking people to take wage cuts or start laying people off in an unsystematic way. They couldn't sustain their structure. And they asked the CCAC, the government, local MPPs, can we renegotiate our contract price for now, partly because we have 2,500 clients here in Hamilton who will suffer if we go under. And also because the alternative providers in Hamilton, which were all for-profit companies except one, actually had contracted with the CCAC for higher rates, so it'd actually be a cost generator for the CCAC to see them go under. All those appeals went nowhere and they were told the contract had to stand as it was, that market rules

prevailed, that nobody could do anything about it. So the agency declared bankruptcy. Three hundred-plus workers got laid off—front-line workers—and 2,500 clients had to be transferred to other agencies. So major disruption for those clients and for the workers concerned.

"I followed them out twice, a few months after the closure and then a year after, and 62% of them had left home care altogether. Some of them were still unemployed at four months; 62% said they would not stay in home care. One woman I remember saying to me, 'I can't afford it.' Of those who did, 38% of the total—it was a group of about 45 or 50—went to alternative employers, most of whom were for-profit.... One woman I remember particularly said, 'I went to agency X, because this elderly person I'd had a relationship with for years, who was used to me, who I didn't want to see suffer—they transferred her there so I went there too.' When she got there, she got paid less. So there was a sort of irony: She got paid less while her new agency got paid more by the CCAC than had her defunct, bankrupt non-profit agency. And this was deemed a reasonable decision."

If the Ontario government is sincere in its assertions that they have no intention to introduce a competitive bidding model into the broader health care system, then concrete safeguards have to be written into the legislation to this effect. Bill 36 must be amended to ensure that services will be integrated only amongst not-for profit providers and that the government will not use competitive bidding in the allocation of funding for health services.

The second issue is the privatization of services. There are two sections in the act that point to an agenda to privatize health services and increase the delivery of health services by for-profit companies.

Section 28 of the act essentially gives the Minister of Health the right to seize the assets of a not-for-profit health care service and transfer those assets to another health care organization. The Minister of Health does not have similar powers with respect to for-profit health care services. As a result, the minister could, under Bill 36, seize the assets of a not-for-profit home for the aged—say, for example, the Perley health centre—and order it to cease operations, fire the board of directors and generally significantly change the ownership structure. However, the minister will not have similar power over a for-profit nursing home in the same city—for example, Extencicare or Versacare. As a result, if there is a determination by a LHIN that there are too many long-term-care beds in Ottawa, Bill 36 provides protections to for-profit nursing homes at the expense of not-for-profit homes for the aged. That, in and of itself, will mean that not-for-profit agencies will be at a significant disadvantage when decisions are made to rationalize health care.

Second, section 33 of the act allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. This means that the government can centrally dictate how all non-clinical services are to be provided by hospitals, long-term-care facilities and other health providers. It

allows cabinet to privatize the delivery of these services by contracting them out to companies like Sodexo, Telus or IBM without debate. It allows cabinet to take these services completely out of the purview of the health sector.

My first issue with this section is its general assumption that non-clinical services are not really health care and can be provided by a non-health-care provider. All of our members, whether they are in the kitchen cooking the food or in the bathrooms cleaning the toilets or in the office organizing the records, are health care professionals. The work they do is part of the health care system and needs to be recognized as such. In our hospitals, these employees risked their lives to go to work during the SARS crisis. Hospital cleaners, as we all know, are vital to preventing the spread of infection, and every food and nutrition employee can tell you that you don't get well if you don't eat well.

1630

Section 33 gives cabinet the authority to contract out these services despite the wishes of the health facility. Not only will it result in significant layoffs and job loss for our members; it will also mean that our public dollars are being spent on the profits of corporations instead of on improving care. Just to let you know, CUPE will not stand down if these services go to companies who are going to skim 10% or 20% of their revenues towards profit. This is not an efficient spending of public health care funds.

If the provincial government is sincere in its claim that Bill 36 will not result in the increase of private for-profit health care, then sections 28 and 33 should be scrapped.

The final section that I want to comment on is the issue of accountability and consultation. We have strong concerns regarding the dearth of mechanisms to ensure that the public have a say in LHINs decisions before, during and after they are made. The LHINs are not structured to conform with the known community of interests within our province. They do not conform to our political boundaries at the riding level, at a municipal level or even at a regional level. What does Bancroft have in common with Scarborough? What does Deep River have in common with Ottawa? Civil society does not structure itself around the boundaries created by the LHINs. There is no political history or political culture that allows the people in Cornwall to travel three and a half hours to meet with people in Mattawa.

Board members are not elected by and are not accountable to the population that they serve. Board members are appointed by the Minister of Health. They are accountable only to the Minister of Health. There are no specific provisions in the act mandating meaningful consultation, transparency of decision-making or public avenues for appeal. Board members do not answer to the public for the decisions they make. Members of the public have no legislative vehicle for protesting decisions made by the LHINs.

I have a series of recommendations that we are proposing:

We need to provide for the democratic election of LHIN directors by all residents in the geographic area.

There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect the real communities of health care interest so local communities can have an impact on LHIN decisions.

We need a ministerial obligation to meaningfully and fully consult with the community prior to imposing an accountability agreement.

We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-unionized employees.

We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public.

Thank you for listening to our concerns.

The Chair: Thank you very much for your presentation. There is no time for questions on this. Thank you again.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1559

The Chair: The next presentation is from Rebecca Phillips from CUPE, Local 1559. CUPE, Local 1559 already spoke earlier. I believe that's the second one from the same union?

Ms. Rebecca Phillips: Yes.

The Chair: All right. Please proceed. You have 15 minutes total time. You can start any time you wish.

Ms. Phillips: My name is Rebecca Phillips. I represent CUPE, Local 1559. I've worked at the Access Centre for Community Care in Lanark, Leeds and Grenville for 16 years. It's taking an extraordinary effort for me to be here today to speak to you. Unlike many who have spoken before me, I am a novice at public speaking, so bear with me. But I strongly wish you to hear our concerns about Bill 36.

All of us want quality health care for Ontario. We want quality employment as well, and viable communities. That's important. Bill 36 is a start, but it most certainly needs amendments.

Our first concern is that there is no community control. The legislation ignores accountability to health care users. There is no community control of health care, largely because the board would be appointed, yet the minister talks about bringing decision-making closer to home. An appointed board covering my LHIN area, from Belleville to Cardinal and north to Madawaska, is not what we call close to home. There isn't anything in the legislation that ensures that all communities will equally be part of the decision-making—or be part of the decision-making at all.

Mr. McNeely, representative of Ottawa—Orléans, mentioned in a recent assembly debate that they will get a large LHIN area with Ottawa being the core of it. In referring to the LHIN board CEO and chair of the LHIN board, he said: "It will certainly be a group of people who will be able to make the decisions to the benefit of the

people in the Ottawa area." Then he continued on to say: "We're going to have equity in the system."

There's no equity in a system that will pull away health services from small communities. If services go to the companies and agencies that are best set up to handle mass quantities of patients for procedures like cataract surgery, eventually hysterectomies and other procedures, the smaller communities that make up a large part of Ontario will suffer. In the evaluation process of the bids, it seems reasonable that locations requiring the least amount of people to travel would be preferred, which would mean cities with larger populations like Ottawa, Kingston and Belleville. Of course, larger cities are doing the majority of procedures anyway, but certainly if small communities don't have a voice, more and more of the procedures that we perform now will get pulled away. It will mean far fewer jobs.

It will also mean travelling unreasonable distances too often to obtain services. If I had more time, I could describe to you the painful challenges that people in our community already have getting to health services. I provide information and referral for the access centre. I take calls from the public looking for community services like transportation. I know the challenges that they face. Centralization will make accessing health services many times worse for seniors, disabled people and those who don't or can't afford to drive. Any health care money gained through efficiency will be needed to pay for transportation to access care.

We want someone on the LHIN board from our community, someone who we feel is open to listen and can relate to the health care needs in our community and who is accountable to us, the health care users. The legislation needs to be amended to provide for each community the right to elect a director for the board, with the chair and vice-chair being selected by the directors. Local members of the provincial Parliament should be ex-officio directors of the LHINs. It is our health care dollars and our care, and we want someone that our community elects to make the decisions that will affect us in the LHIN model.

Our second concern is that privatization causes job instability and results in decreased quality of care. I want to speak to this because I work at the access centre and we care deeply about the work that we do, doing all that we can so that people receive the care they need when they need it. I see and hear what competitive bidding is doing to jobs as well as the care that patients receive because, as you know, the LHIN model will be based on the contract model that the access centre uses.

Mr. McNeely said that the LHIN "transition is the right thing for health care and there are going to be growing pains and certainly people will be hurt during the transformation." Yes, there will be growing pains, and yes people will be hurt during the transformation to privatization, but it doesn't stop there. Ask health service workers being bounced around from service provider to service provider, depending on who has the contract for home care with the access centre, if they were hurt during the process. They would tell you that they wish it only hurt during the transformation because, in reality, it is the

perpetual never-ending job instability that hurts. Being laid off and having to reapply for the same job with another company each time a contract ends—there is no end to the hurt with this competitive bidding model. This government can do much better for Ontarians.

Unlike non-profit services, private companies provide the service to make a profit. To get the contract but still make a profit, they employ part-time or on a contract basis. If this legislation is passed as is, up to 200,000 Ontarians risk losing secure, full-time employment for part-time or contract work with significantly decreased wages and decreased benefits or pensions.

When the ministry switched access centres to a competitive bidding model to decide which agencies would provide their in-home and school health services, it opened the bidding up to private companies, just as the LHIN legislation would do on a much larger scale. As a result, private companies came from nowhere with large purses and underbid the non-profit companies. They got the contracts and forced the non-profits to close. Laid-off employees then had to apply for their same jobs with the company that got the contract, at less pay and less benefits and no job stability because in three years, when the contract ended, they were out of work again.

1640

Two days ago, I was talking with a nurse coordinator whom I see often. She works for a private company that has a contract with the access centre. We ended up talking about the different services that they provide and how their company has grown. She pointed out that when they got a contract to provide home support for the access centre, they hired close to 200 home support workers. We both wondered what they will do with those 200 home support workers when the contract ends. Neither of us said this out loud, but I knew she was thinking that too. They will ultimately be laid off and have to reapply to the agency that gets the new contract, likely getting rehired for less pay and benefits. Competitive bidding has driven wages and benefits down in the home care model.

Last week, I bumped into an occupational therapist who works for an agency that has a contract with the access centre. She told me that she was hired by the company on contract; she used to be a full-time, permanent occupational therapist for the access centre. I'm not sure how her contract works, exactly. I asked her how she liked it. She shrugged, with a look of apathy, and replied, "It's fine if you don't need benefits." I asked her if she needed benefits, and she said yes.

The legislation opens the door for privatization of services. What you need to know without a doubt when you make recommendations for changes to Bill 36 is that if privatization and competitive bidding aren't safeguarded against in the legislation, then quality of jobs and the quality of services for Ontarians will suffer.

When the VON closed its doors in our community—sorry, I need to correct that: They didn't close their doors; they stopped providing nursing services when they lost the work from the access centre—I am told that 90% of those nurses went to the hospital sector, because they

didn't want to work for a private company for below-normal wages, with minimal mileage and no benefits. One company now, rather than paying hourly, I am told, pays based on a set time for each procedure: for example, 20 minutes for a dressing, 10 minutes for a blood pressure and so much time for travel based on the distance. Therefore, the more patients the nurses see, the more they are paid. They must try to see as many patients as possible to be paid as much as hospital nurses.

The pressure these companies have to make a profit takes its toll on patient care. Often, staff are not guaranteed full-time hours, yet they need a certain number each week to qualify for benefits, so often employees have no benefits, not to mention a pension.

A nurse who has worked for both non-profit and private companies described to me how one loses their sense of dedication and respect for their employer, how one has less enthusiasm and respect for the job that they do when the almighty dollar comes before the patient. I think this would be true in all health and social service jobs. It doesn't matter whether contracts are awarded based on price or not; without a doubt, a profit is what private companies will be looking for, and they are the ones that will be providing the services. Therefore, we can avoid negative effects on jobs, people, service provision and our communities if the legislation includes concrete safeguards built into the legislation to prevent competitive bidding and contracting out.

If I had time, I would tell you more about how privatization affects quality of care, but let me just say that a case manager told me that they were seeing a lack of dedication from companies that set up shop because they get a contract. For instance, a company was given a contract for medical equipment for the CCAC. In one case, they delivered the wrong stomach tube for feeding a child. A weighted tube was ordered, but a plain tube was delivered. They couldn't use it to feed the child. When the case manager called to have the correct one delivered, she was told that they didn't know when it could be delivered. Their company was from a city larger than ours, so it was a distance away, and it would be some time in a six-hour window when they could deliver that tube. The case manager was mortified, knowing how the child's mother must feel, not being able to give her very ill child nourishment. She told me that there is a distinct and definite difference in the sense of dedication and obligation between a company that sets up or expands to a community just for a contract and a company that was part of the community and has a history with the agency. Contracts negatively affect quality of care.

There isn't the sense of community or obligation to take care of the people in the community. She described that when private companies pay below normal, pay low mileage and don't have a pension plan, nurses and homemakers don't go out of their way, because they don't feel respected for what they do. We all know that we get what we pay for in everything.

She told me that it's harder and harder in small communities to get homemakers and nurses, because the companies don't pay them enough. Access centres have

waiting lists for services because there aren't enough nurses and homemakers employed by the agencies. The access centre even has a waiting list for palliative care. Access centres strive hard to arrange care for people in their homes when they need it; illness and death don't wait.

Is this the right thing for health care? This government has come up with legislation that's based on the principle of whoever can provide the best care in the best fashion will be providing that care. If this legislation is passed as is, this government can add "at whatever cost"—the cost of quality service, decent jobs, community viability and access to care.

In conclusion, we ask that this committee strongly consider supporting that the following two amendments be made to the legislation so that the viability of small communities, job stability and quality of health care are protected: Specifically exclude competitive bidding from the legislation and provide for each community the right to elect a director for the board, with a chair and vice-chair being selected by the directors. Local members of the provincial Parliament should be ex-officio directors of the LHINs.

We'd like to thank this committee for listening to our concerns and suggestions.

The Chair: Thank you for your presentation. We'll move on to the next presentation. There is no time for questioning.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1974

The Chair: The next one is the Canadian Union of Public Employees, CUPE, Local 1974, Kingston. Louis Rodrigues? Please have a seat at the front. You will have 15 minutes if you wish to speak to us, and if there's any time left, we will be able to potentially ask questions of your statement. Thank you.

Mr. Louis Rodrigues: Thank you. My name is Louis Rodrigues and I am the president of the Canadian Union of Public Employees, CUPE, Local 1974, representing over 1,400 hospital workers at Kingston General Hospital. As well, I hold the position of first vice-president of the Ontario Council of Hospital Unions, OCHU, representing approximately 25,000 hospital workers province-wide. I am pleased to be here today to express concerns on behalf of my members.

I submitted my submission; I was hoping to do my submission, but actually get into some personal issues, not the follow-through, as I'm sure you've heard—I've been here most of the afternoon, and it gets repetitive. They are major issues, major concerns, but I don't want to go on and on over the same issues.

At Local 1974, we have the same concerns as expressed here earlier: privatization, contracting out and competitive bidding. I've heard the response from the committee that that's not the intent or whatnot, and like previous speakers, I do say that if that's not the intent, let's make it clear.

I've been an employee of Kingston General Hospital since 1972. I started working there in the kitchen as a cleaner. Over the years, I worked myself up to chef. I'm a certified chef, and the reason I say "certified" is, I used to take a lot of pride in what I did. A time came when regionalization and restructuring were major factors across the hospitals in order to save money. Our food comes from Ottawa, the hospital food service, HFS. Our food comes in in bags and containers. It's frozen, and we heat it up and send it to the patients.

I did not lose my job; I lost my dignity. I used to have pride in what I did. I'm still employed; I'm still making the same wages—I don't mean I'm making the same wages; we've negotiated a new collective agreement. I continue to work there and get the essential increases that we were able to attain through negotiations. But what I lost was the dignity of providing the services that I was qualified to do. I took a lot of pride in preparing the best food possible. I spent a lot of nights going to school, raising my family and earning—at that time, it was probably around \$7 an hour, looking at 1972, to do the services that I thought I could do.

1650

My family was in construction. I quit school at the age of 16, and it was important to me to put some time in, because my dad wouldn't have me in the company: I was too young to go into construction. I fell in love with the environment of the hospital. I wasn't too bright then—not that I'm any brighter now; I'm still there. But it was something you learned. You got to know these patients, you got to know the people. I took a lot of pride in it.

If I can turn the clock back, I wasn't born here. I was born in Portugal in 1955. I emigrated to Canada in 1966. What a wonderful country—not that the climate was any better; I'm from the Azores. But the opportunities that we had here—education was really, really important. My children have taken advantage of it. I was at an age where it was a little more difficult for me, but what was offered here was for everybody; most important, the health care services.

I don't know if we have the best health services in the world, but they rate among the better. I come from a small community, and the closest hospital—I'm just estimating here—is probably a two-hour drive away. I had surgery in the hospital—an arm. I can show you the scars, and I'll have them for life. The surgery went well—good hospitals, good doctors—but no services in my community for after the surgery. What I have are scars that will be with me for life. My brother, at the age of five, fell and cut his ear. It was just hanging through the bottom. He had to be transported to a hospital miles away. He also has scars for life. We do have doctors, and it wasn't that the community I come from was still in the horse-and-buggy era. Actually, the doctor drove a Mercedes. But the first-come were people who had the cash to pay for the services. How many children were lost on the way to the hospitals? How many people have suffered injuries that will be with them for life? I don't know that. I know that it's important. But I'm not here to speak about myself. My parents also emigrated and I'm

proud to say that everybody in my family is a Canadian citizen by choice.

What was the most important thing here? Freedom. We come from a country where dictatorship was the norm. Here, we had the freedom. Slowly, we see it going away when, through legislation, through a proper process, people make decisions that impact whole communities on how something as important as health care—you can say education or social services or whatnot—can be changed through legislative dealings. I'm not saying it shouldn't be changed. It should be consulted. Talk to people. What's the impact?

I'm not sure what the act actually says. We hear from the people who advise us that there are a lot of dangers in this bill. We hear from the promoters of this bill that that's not the intent. For me, it's a very simple solution: If it's not the intent, why does it exist? I don't want to say that we've been fear-mongered; that's not it at all. Why is it that our people feel that there are dangers here? Through previous restructuring in Kingston, we can talk about what happened with the Hotel Dieu and Kingston General Hospital. It was the same as these LHINs: local agreement. Local agreement was wonderful when they were doing the paperwork. Once the ink dried, everybody was in the courts. It took years. Hotel Dieu was slated to be closed. It's still open today. I'm glad to say that both hospitals are working together and moving forward, but it took a long, long time, major expenses and a lot of animosity within the community.

We see this as opening up the door to many, many downfalls. We've seen that in Picton. There were services there that were supposed to be closed. They mounted a campaign with over 500 people showing up at their meeting to talk about the closure of these services in Picton. We don't want to see major disruption in the health care sector. We need to rethink where we're going with the health care services.

We have a lot of issues that we can talk about—and please forgive me; let me know when I'm running out of time, but—

The Chair: You have five minutes.

Mr. Rodrigues: I'm doing fine.

A key goal to reform is to look at all avenues. Nobody is trying to propose that we shouldn't consolidate services if those services benefit the communities. I would have been really proud if this committee had come to Kingston and given my members and people in Kingston the opportunity to be heard. I don't know how many people put in to have standing at this committee, but it would have been nice. It would have been nice if we'd just spent the time to see how this is going to be beneficial to us.

Cost savings are very important; I understand that. The confusing thing for me is when you hear that this is the best time that Canada has ever had. We're into surpluses, unemployment is down, but we can't afford health care. Is this the mandate of our people? Are our MPPs telling you that their communities are supporting the opportunity to privatize, contract out to the lowest bidder, competitive services? We're afraid of working in

one hospital and two years later applying to another hospital. We're afraid of what's going to happen if it is a non-union environment. I've been unionized all my life and, to be totally honest, I don't know if I'm here speaking on behalf of the union, on behalf of my family, on behalf of my community or all of the above. It is a major thing that we have to look at.

These people are committed. Earlier on I told you that I started working here in 1972. I'm now getting closer to my retirement, but I'm proud to say that my youngest son just started at the hospital about a year ago. I'm hoping he can make a career out of it like I did. I lived modestly, I raised my family, I was able to give them an education and we're very comfortable. We're not wealthy, but we've got a decent job, a well-paying job, a secure job. What we see here is our job security gone, uncertainty, bidding for another job every two years, losing services in the community, the fear of travelling 100 miles or 100 kilometres, 200; I'm not sure what this is going to do. There are a lot of uncertainties there, and all I'd like to do is urge this committee to put pressure, slow it down, have some proper consultation and see if there are better ways, long term. Look at buyout packages or retraining people, look at job security. These people are committed for the long haul, and they deserve the security and the respect that we should give them as users of the health care system. We are there for the people, and I'm sure that we will continue to fight this bill or try to make amendments to this bill so that it's going to be a benefit to everyone.

The Chair: There is a minute and a half if you wish to speak. Otherwise, I'll ask the members to take 30 seconds each. We'll do that. Why don't we ask Madame Martel; maybe she has a question for you or a comment.

Ms. Martel: Do you know what? I don't. I think you said what you had to say and you said it very well, and I appreciate that you took the time to come here today from Kingston to have your say. On behalf of yourself, your members, your family, whoever you wanted to speak about, thank you very much.

Mr. Fonseca: Yes, Sr. Rodrigues, thank you very much for your presentation. I was also born in Portugal and I've come here. The LHIN legislation, how I see it and how our government sees it, is really about building our health care system and it's for sustainability. It's in place so that the hospital, the community health service providers and those who have not had a voice in health care are at the table, because it has always been only about the hospital. We want to make sure they have a voice and we can have an integrated system.

We have 14 LHINs, but there is a provision in the bill that if they're not local enough, if they're not addressing those local needs, more can be created. There can be more LHINs; there can be more than 14. We've learned from other jurisdictions. In the BC model, they started with 50 and have kept bringing theirs down. This is an evolutionary process, and it's really about the sustainability of our health care system so that your son can work in health care and others can for the long haul.

The Chair: Thank you, Mr. Arnott.

Mr. Arnott: Thank you, Mr. Rodrigues.

The Chair: Thank you. I think you made clear what you wanted. We thank you for your presentation.

1700

SPECIALTY CARE GRANITE RIDGE

The Chair: The next presentation is from Specialty Care Granite Ridge, Linda Chaplin.

Ms. Linda Chaplin: Thank you very much. Good afternoon. My name is Linda Chaplin. I am the administrator of Specialty Care Granite Ridge, which is a 224-bed, licensed long-term-care home in Stittsville, which is now West Ottawa. Granite Ridge was constructed as part of the 20,000 new long-term-care-bed initiative, and it opened in late 2002.

I welcome the opportunity to present to you on Bill 36. In part, I hope to give you a somewhat different perspective on this legislation, and it comes from being part of an organization, Specialty Care Inc., a company that provides the same services in 13 homes in seven different LHINs.

Overall, I welcome Bill 36. Like my colleagues and community partners, I've always believed that we could do more to improve health care services for the people of our community. More often than not, our ability to do this has been stymied by the constraints of our silo-based system. In its vision, Bill 36 provides a framework that offers me hope that we can finally break down these system barriers. The task is now to effectively translate the major elements of Bill 36 into the reality that is Ontario's health care delivery environment.

Long-term-care homes are a major part of this reality. Granite Ridge is one of 600 homes throughout Ontario that deliver a provincially funded and regulated service on behalf of government. We are a private provider, yet we deliver the same service within the same operating and funding framework as our not-for-profit, charitable and municipal colleagues. We are per diem, not globally, funded, and it's based on our total number of licensed or approved beds. This means that government directly controls provincial service levels, as well as the service level in each home.

However, unlike most other health care services, residents pay approximately one third of this per diem. Residents in Stittsville in West Ottawa write the very same cheque as residents in Ottawa East or Thunder Bay, and they naturally have an expectation to access the same level of service. The potential for Bill 36 to negatively impact this equity is a major concern for my home in two specific areas: (1) core service delivery, and (2) core service accountability. The manner in which Bill 36 currently devolves authority creates the potential to de-standardize and destabilize both service levels and service providers, while adding significant and unnecessary administrative costs.

As I indicated, the minister currently has authority over long-term-care services through a governance and operating framework that's tied to licensed and approved beds. The ministry issues a licence to Specialty Care Granite Ridge, other private, not-for-profit, and some

charitable homes, for the number of beds that we operate. The remaining charitable and municipal homes have ministry-approved beds. This mix of licensed and approved beds results from three separate acts currently governing operators. My per diem operating funding is linked to my licence and, as such, adjusts directly with any changes to the number of my licensed beds. The same process applies to homes with approved beds.

As a licensed operator, I have a second area of exposure. My licence and the number of beds attached to it was used by the bank when it decided the terms on which to lend Specialty Care a portion of the funding required to construct this new home. Any reduction to the number of licensed beds will impact those terms and thus increase the risk to Granite Ridge as a service provider to the Stittsville and West Ottawa community. In short, Granite Ridge's service is, in fact, its beds.

As you know, government is presently developing a new long-term-care homes act, which may be tabled in the Legislature within the next few weeks. The government's consultation document on this new legislation contains a whole section on the treatment of licensed and approved beds. As a result, we fully expect that in the new act the minister will retain total control over beds and thus over service. In fact, this is appropriate, given that long-term care is a provincial program. It does mean, however, that the language of Bill 36 to devolve service authority to the LHINs is inconsistent with this for long-term care. This inconsistency must be resolved in Bill 36 to mitigate the resulting risks to both residents and providers.

As currently written, the relevant parts of part IV, section 20, provide me with no assurance that my LHIN will fund all of the beds that the province licenses me for. This places the future of those 224 residents who call Granite Ridge their home at risk, and it also increases uncertainty for the 133 citizens on my wait list.

This uncertainty can be removed with language changes that would require LHINs to fund homes consistent with their provincially licensed or approved bed capacity. Specifically, part IV, subsection 20(1), should be amended by adding "where a health service provider is a long-term-care home, the service accountability agreement shall provide funding for the home's total capacity of licensed or approved beds."

As a matter of policy, I am hoping the government will also retain a common approach to funding core services, including the elements of our current envelope funding system. This system was developed for accountability purposes, and one of its most important elements is to ensure that there is no profit made on care and program services.

Centralized funding tied to provincially licensed bed capacity for core services would not negate my home's ability to participate in local service enhancements. In fact, it provides the opportunity for homes to pursue local opportunities and solutions without compromising core service delivery. At Granite Ridge, we are already doing this by participating in the new convalescent care program. We see potential opportunities for other special-

ized services that will help relieve the pressure on hospital service delivery, such as on-site IV therapy.

Bill 36's ability to support homes in delivering this vision can be enhanced by strengthening the authority and flexibility of LHINs to support local solutions within a fair and transparent framework. This could be accomplished by, first, amending part IV, subsection 19(1), to read, "A local health integration network shall provide specialized program funding as deemed appropriate to the health service provider, based on the local population's unique needs"; and, second, by amending part IV, subsection 19(2), to read, "The funding that a local health integration network provides under subsection (1) shall be on terms and conditions that the network considers appropriate with consultation with the respective health service provider(s) and in accordance with the funding...."

As a final comment on the implications of Bill 36 for equity and stability in access to core services, I would like to briefly address part V, section 28. Placing homes and their services at different degrees of risk based simply on the type of operator would be turning back the clock in Ontario. The difference was eliminated when the current program governance and operating structure was established in 1993. The sector and long-term-care residents have benefited greatly from this standardization. Initiatives leading to de-standardization would be both regressive and contrary to Bill 36's objective to make the system seamless for the patient or resident. If the basic service in all homes is the same, and the authority over that service already resides with the minister through the control of the beds, then the application of integration orders and minister's decisions to operators should also be the same. Exempting all licensed and approved bed operators from section 28 would accomplish this.

I will now turn to the implications of Bill 36 for core service accountability. This bill creates the potential for two parallel accountability processes in long-term care. One is local, from the service accountability agreements between the LHIN and operators, and the other is provincial, from the inspection criteria we expect to be outlined in the new long-term-care homes act. As an administrator, I could end up being accountable to two authorities with different performance criteria for the very same service. This would be unnecessarily complex, with potential for risk and misunderstanding for me, my staff, my residents, and of course their families. It would support the de-standardization of core services within and also between LHINs.

This potential can be eliminated by adjusting Bill 36 to be supportive of the accountability framework that will be included in the forthcoming long-term-care legislation. This can be accomplished by establishing a single and consistent service accountability agreement that would enable LHINs to discharge their responsibility for ensuring compliance with provincial performance measures. This instrument would be conceptually similar to the standardized service agreement that now exists between the ministry and all homes.

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Language should be added to part II, subsection 20(1) and part IV, subsections 47(7), (8) and (21), to ensure that this standardized agreement is developed in regulation. Further, this language should stipulate that the development process should include consultations with sector associations. The latter point helps ensure that the agreement accounts for the various governance structures in our sector: private companies, publicly traded companies, not-for-profit, community boards, and municipal government.

The front line in Ontario's health care system is already difficult. We will only add more stress if we foster service variations by devolving core service accountability to the local level. This is what occurred in Alberta. We have some examples of that.

Given the already increasing administrative burden, I am not looking forward to jockeying with the over 200 other health care service providers in my particular LHIN for time to negotiate individualized service accountability agreements each year. I would, of course, expect to work directly with my LHIN on amendments to standardized agreements to account for any specialized local services that I deliver on their behalf.

The foregoing impacts will be magnified in multi-site organizations. My service quality benefits from my ability to share common experiences, management processes and solutions with other Specialty Care homes. These benefits, however, will disappear if we are funded differently, with different performance accountability targets and criteria. These are not the only areas of Bill 36 that raise concerns for multi-site operators.

Over 60% of the operations in Ontario are operated by multi-site operators. These would include private organizations such as Specialty Care, as well as charitable and not-for-profit organizations, and municipalities that operate more than one home. In many instances these organizations, like Specialty Care, span individual LHIN boundaries. All of these organizations have achieved degrees of the LHIN vision of integrated service support processes and functions. These processes and functions are often referred to as back-office integration. They can range from shared professional resources, such as nursing and dietary consultants, to IT platforms and payroll systems. It's worth noting that in many companies and organizations this integration often incorporates functions beyond the long-term-care service program and way beyond the scope of Bill 36. For private, not-for-profit and charitable operators, it can actually include retirement homes or home care services. For municipal operators, it could include other municipal departments and services.

In the lead-up to LHINs there is increasing discussion around quick wins that often focuses around back-office integration. Bill 36 supports this direction in part V, section 23, with a broad definition of service to which integration orders can apply. If LHINs begin to exercise the full authority in this definition, they will create significant business and operational issues for multi-site providers that will adversely impact service efficiency

and costs. There will also be unintended consequences for operations over which Bill 36 had no envisioned application. I believe it's appropriate that this committee move to eliminate this impact by changing the language to part V, clause 23(c) to exempt those functions that support the operations of licensed or approved long-term-care beds from the definition of services.

Ladies and gentlemen, I started my presentation by stating that I was encouraged by the prospects for Bill 36 to break down the barriers of our current silo-based system. Over the past few minutes I have outlined some changes that I believe could strengthen Bill 36 in the context of the reality of long-term care.

I'd like to close with a final recommendation. I'm referring to the implementation of a health professions advisory committee in part II, subsection 16(2). It's true that we're all health care professionals. It's also true that we have been silo-based for so long that unless you've worked for an extended period in different sectors—which I in fact have, after 30 years—the clinical settings in other sectors can be foreign. The health professions advisory committee must have the ability to speak from that experience on behalf of acute, long-term care, mental health, home care and the community sectors to provide, and be seen to provide, credible advice to LHINs. In view of this, language should be added to this section to not only define the committee's term and mandate, but to also define in regulation that it contain a minimum of one regulated health professional from each sector. Thank you.

The Chair: Thank you. There's about 30 seconds each. Ms. Wynne, would you start, please.

Ms. Wynne: I want to thank you for coming. We've heard some of these issues from at least one other group that's come before us. I know that you will have dealt with Monique Smith, my colleague who is working on the long-term-care legislation.

My question to you is, given that you've given us some specifics around your sector and some concerns, in terms of the overall benefits of the integration of the local health integration networks, can you see long-term benefits in terms of your sector, as well as generally?

Ms. Chaplin: Oh, I absolutely can. Even in the lead-up to LHIN formation, in the dialogue that preceded some of the consultation process, the intrasector communication was quite remarkable. There was a breaking down of that silo base that can make sectors appear to be operating totally in isolation one from the other, when in fact we're all there to serve the same purpose, and that is to meet the health care needs of all ages and all conditions.

Ms. Wynne: That's great. Thank you very much.

Mr. Arnott: I don't have any questions, but I want to thank you for your presentation. You've done a great job and you've given us some specific amendment ideas, and we appreciate that.

Ms. Martel: Thank you for being here today. You referenced section 28, so you know that's been a cause of concern for a number of groups before us. What would happen if we just eliminated section 28 altogether?

You're asking to be exempt from it, but that might help long-term-care operators in the not-for-profit and for-profit sectors. It wouldn't change much for other not-for-profit agencies that may be delivering other services that are not long-term-care beds. So if we just eliminated this section altogether, so that there's no distinction between any operators in any sector, would that do it for you?

Ms. Nancy Cooper: My name is Nancy Cooper. I'm from the Ontario Long Term Care Association. Within the definitions laid out in the act, the only health service providers that are for-profit are nursing homes or long-term-care homes, so the application to other organizations is beyond the realm of the bill, what's being suggested. The health service providers that are affected are clearly named, and home care providers are not named; they're part of the contract to the CCACs. They're outside of the bill. So what we're putting forward is that because long-term care is a standardized provincial program, whether you are for-profit, not-for-profit, municipal provider, we should all be treated the same because we're all funded and regulated in exactly the same manner. Therefore, we all should be exempted from section 28.

The Chair: Thank you very much for your explanations and thank you for your presentation.

OTTAWA AND DISTRICT LABOUR COUNCIL

The Chair: The next one is the Ottawa and District Labour Council, Sean McKenny and Bruce Waller. Gentlemen, you can start whenever you're ready. There's 15 minutes total time for your presentation.

Mr. Sean McKenny: I thank you for that. A number of years ago, an individual said to me that I pronounced my name wrong, that it wasn't "Shawn," that in fact it was "Seen" and my name should be "Seen" McKenny. And I said, "Well, it's Sean and it's pronounced 'Shawn,'" and he said, "Well, what about 'Seen' Connery?" That's a true story.

In any case, my name is Sean McKenny, president of the Ottawa and District Labour Council. With me is Bruce Waller, newly elected president of CUPE, Local 4000. I'll commence, and then Bruce will come in to polish up and close off our submission.

The labour council in Ottawa is comprised of 90 affiliated local unions representing approximately 40,000 working men and women in all sectors within the city.

Perhaps most perplexing and frustrating for us once again as we address the proposed legislation is the claim by a government that it is committed to those who are employed in our health care system. In fact, actual wording in this instance as it relates to Bill 36 is—and I quote the provincial government's line appearing in numerous documents and repeated over and over—"The Ministry of Health and Long-Term Care is committed to working with our province's dedicated health care professionals to improve the health care system because Ontarians deserve the best health care."

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You're not going to have an argument from too many people, if any, that those employed within our health care system in this province and elsewhere are an incredibly dedicated and loyal group. These are individuals who, by their very nature, are committed to ensuring that the care provided to those in need of services in our communities is only the very, very best.

We as a labour council, whose affiliates are these workers, take more than notice when the claim is made that the proposed local health integration networks are deeply flawed. They know the system best; they work in it every day. They see the problems; they envision the resolve. They know our health care system better than I do, and I can assure you that they know it better than any of you around the table.

Some argue—and I find it so incredibly unfortunate and, quite frankly, extremely disrespectful—that the workers', that the unions' only and sole interest is to protect their jobs. Protect their jobs? Absolutely. Yet it's only a part of the overall passion and compassion that all those employed within the sector exhibit on a daily basis, because when they protect their jobs, they're protecting our health care system.

Michael Hurley, the president of the Ontario Council of Hospital Unions, says, "The changes that are being planned will result in the slow destruction of our local hospitals," and he adds: "The lowest-bidder approach for health care services that the Liberals are unleashing under the LHINs threatens both access and quality of services." Is he lying?

Sharleen Stewart, president of SEIU, Local 1, says that LHINS are "just the next step on the road to more health care privatization." I suppose that's another lie.

Leah Casselman, OPSEU president, predicts massive job loss and disruption for patients. Again, I guess she's wrong, too.

The message is being delivered in respect to Bill 36 that there exist major flaws. Perhaps most disheartening would be if the government was in fact hearing the message, yet moved towards the LHINs implementation without regard for the comments and opinions based on facts presented by those individuals who know our health care system the best—the workers.

On the other hand, if the provincial government's intent, through the Ministry of Health and Long-Term Care and through Bill 36, is to in effect cause the destruction of our local hospitals, cause massive job losses, negatively affect access and quality of services and privatize our health care system, then the need to listen and act upon the recommendations being put forth by those as noted above becomes moot.

The majority of those employed within the health care sector have stated that they no longer trust the McGuinty government to protect our public health care system. The implementation of the local health integration networks in their proposed form through Bill 36 further solidifies that lack of trust.

We urge this committee, when reviewing these submissions, to give the appropriate weight to those

presentations and reports made by those individuals and organizations whose commitment to our health care system on behalf of all our communities and the people in this province is far above most others, and those individuals and organizations are the women and men who work in our health care system each day, every day. Thank you.

The Chair: Congratulations to the new president.

Mr. Bruce Waller: Hi. My name is Bruce Waller. I am the president of Local 4000 in the Ottawa Hospital.

I guess we'll continue on with what Sean was saying. This is part of the erosion of health care as we know it today, and I don't think this was the way health care was set up many years ago, for stuff like this to happen.

The first thing on the agenda is, these LHINs boards are going to have control of these monies; the hospitals are no longer going to have control of their own budgets. How can you run a business without a budget, without having money on hand to do daily stuff? My understanding is, they're going to have to go to the LHIN's board, make a presentation and then get this money back. The way the board was appointed—I mean, as a taxpayer in the province of Ontario and living here all my life, I find I take offence at the fact that I don't even have a say in who appoints these people. These people were just appointed. I elect my school board officials. I elect my city officials. We elect you people around the table to represent us.

Mr. McKenny: Some of them.

Mr. Waller: Yes, some of them. Sorry.

This was just a board appointed by the minister and a couple of other people on his committee, I imagine, and then the CEOs of these boards appointed other people on these committees who had business experience, I imagine. But just the whole process itself is definitely—I mean, in a democratic society I find that it's not democratic. For sure, it's not democratic. So that's the first thing: How can we just appoint people to this board? It's going to control all these monies and all these sections. Then there's a clause in there that even if the LHIN's board does agree somehow with the union to say that we can't do any more cuts or we can't move this service or we can't merge that service, it's inefficient, it's not going to work, the minister has the power to make them do it anyway. So why are we appointing this board in the first place, then? What's the purpose of the LHINs if we already have the OHA, the Ontario Hospital Association, to do this stuff? We're just appointing another level of bureaucracy at a cost to the taxpayers that's going to far exceed the costs they're going to save. We already know they didn't save any money merging hospitals under Bill 136. The proof is already out there. The numbers just don't add up.

Speaking for my members, the membership of the hospital—when we hear comments from the Minister of Health: "Why should we pay the cleaner all this money when we pay the bank employee \$8 an hour to vacuum the rug?" or something like that—these people are front-line workers. These people deal with sick people. There

are illnesses in these establishments. We're picking up mercury spills. We're crashing rooms that are contagious with diseases, or there's VRE, MRSA—the list goes on and on. Someone in a bank is cleaning the bank. You don't have these diseases on a daily basis. I'm not sure what the number was, whether it was 45 or 54 people who died in Toronto during the SARS outbreak. This really happened. These things happen, you know. The new disease going around these days is C dif. We have to close down floors in hospitals. Wards are closed down because of these illnesses. There are special cleaning procedures in place to do this stuff. I don't think a contractor really cares how these places are going to get cleaned up. He's looking at a profit. If they're in there for cost-plus, what kinds of services are we really going to get in these hospitals? If these places are already saying that they're not cleaned properly now because of cuts over the years, the erosion of services, how are they going to be cleaned in the future? What's it going to look like three to five years down the road? I certainly don't want to be a patient in a hospital if—there are already moulds in hospitals. We all know this. This stuff is there. There is stuff that's still being cleaned up from years ago, with asbestos and everything else, and now we're going to start eroding other services away for a profit. And who's making this profit—companies like Aramark?

So what are we really saving? What do we save when we give a contract to a contractor? Are we saving any money? Why don't we do a cost analysis on if we actually save money? I don't believe we do save money. It has been proven that we don't save money. We probably have data backing up that it doesn't save money. It's just somebody lining their pockets out of somebody else's situation. I don't think that's ethical. I don't think that's right.

I work in the sterilization department. I sterilize instruments for surgeries. I take my job very seriously. If that one instrument gets missed and it's dirty, it gets sterilized and that patient is waiting on that operating table. We want to make sure everything is clean, and we want to make sure everything is up to par. I don't think that's a service that you can just give to Joe Blow down in Toronto or whatever—"Let's ship this stuff up by a truck and say it's sterilized." Does that meet the standards? I don't believe it does meet the standards. We have to wrap this stuff. We have to sterilize this stuff. We have to make sure it's at a certain degree. I don't want to be the person coming back 15 days after surgery with an infection that was caused because an instrument wasn't cleaned properly or somebody cut a corner because they were doing it to make a profit and somebody didn't come in to work that day and it's like, "Well, do you know what? Let's just get everybody to chip in a little more, because it's cutting into our profit."

I'd just like to close by saying thank you for the five minutes. I'd like to thank Sean for giving me the five minutes to speak. I think you people really need to seriously take this back to the proper authorities and say,

"Do you know what? We need some more consultation on this."

The Chair: Thank you. Of course we heard you, and there are also staff of the ministry here who are bringing all the information from everybody. Thanks very much for your presentation.

Mr. Waller: Do you guys have any questions?

The Chair: No, there is no time.

1730

COUNCIL OF CANADIANS, KINGSTON CHAPTER

The Chair: The next presentation is by teleconference. We welcome Michelle Dorey.

Ms. Michelle Dorey: Hello. My name is Michelle Dorey, and I'm with the Kingston chapter of the Council of Canadians. I would like to thank you for this opportunity to express some concerns.

My first concern with Bill 36 is that it does nothing to extend the public health system or promote non-profit health care. The legislation in fact promotes further privatization. The minister may close down, merge or contract out non-clinical services of the non-profit health facilities and services but cannot do the same with the for-profit facilities. We've seen more and more of Ontario's hospitals become public-private partnerships, even though the Liberal Party campaigned against P3s in its election promises. With this move towards privatization in our health care delivery, it's a safe assumption that the newly created LHINs will be moving in this direction as well.

It adds another administrative layer to health care delivery. It's another cost, as well as removing public input or control. Unlike democratically elected school boards, LHINs are appointed by the government. School board meetings are open to the public, but LHIN meetings may be held in camera. So there's a loss of transparency.

Also, the LHIN board personnel may have a bias towards for-profit delivery. Where's the protection or safeguard against this bias? In my region, the director of our LHIN is the owner of a for-profit long-term-care facility. I would be surprised if she did not favour for-profit health care delivery in her LHIN's decision-making.

The LHINs will scrutinize competitive bids from different hospitals for medical procedures. For example, a hospital in Smiths Falls may win the bid to do cataract surgery for the region. This will place a burden on poor people if they live in a city or town not close to Smiths Falls. How will they get a family member there and back? Also, what would prevent a hospital in a nearby American city or town from entering the bidding process? Chapter 11 in NAFTA, which deals with national treatment rights for foreign corporations, would allow foreign bids even if the regulations of the LHINs would try to prevent that. Canadian citizens fund medicare through tax dollars. Medicare should benefit Canadian public health providers, not foreign health providers.

One other aspect of the competitive bidding process which would seem to be at odds with the Canada Health Act is the spirit of competition between providers, as opposed to the spirit of co-operation. Surely, collaboration between health care professionals is more conducive to quality patient care. Also, one wonders if a low-bid hospital would not have cut back on an operational cost such as housecleaning in order to offer a low bid. Perhaps patient rooms would be cleaned every other day, as opposed to every day. So you wonder about the hygiene and whether it would be compromised.

In summary, the biggest problem with the LHINs is the lack of protection and promotion of public health care. LHINs seem to be setting the framework for further privatization of health care. There's also a problem in giving such power and money to these boards when in fact there is very little public transparency or accountability.

Thank you very much for the opportunity to speak.

The Chair: Thank you. We have plenty of time if there are any questions. I will go to Madame Martel.

Ms. Martel: Thank you, Michelle, for participating by teleconference and for taking the time to make a presentation in this way. I don't have any questions. During the course of the public hearings, we've heard a lot of the concerns that you have raised, but I did want to thank you for taking the time to raise them again and for being part of the process.

Ms. Dorey: You're welcome.

The Chair: Ms. Wynne.

Ms. Wynne: Thanks for joining us. It's Kathleen Wynne. I just wanted to clarify a couple of things. The issue of open meetings: The local health integration networks will be required to hold their meetings in public. As a former public school trustee, I can tell you that under certain circumstances there is the possibility for in camera meetings on school boards as well. I'm sure you're aware of that. The majority of the meetings are held in public—oh, hello? She's gone.

The Chair: Is the lady gone? Yes, she's gone. If you wish to make a point, that's fine. There are some people here.

Ms. Wynne: Yes, I wanted to make that point about the open meetings.

I also wanted to follow up on the point that she made about collaboration among providers being desirable. I think that's a key point and it's exactly what we're trying to achieve with the local health integration networks, so that the providers will be able to feed into one plan and that will foster collaboration. I just wanted to make that point.

The Chair: That brings us to the end of this session. We thank all of you for participating here in Ottawa. The next one will be tomorrow morning in Thunder Bay. Again, thank you for your participation.

The committee adjourned at 1736.

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Thursday 2 February 2006

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Jeudi 2 février 2006

Standing committee on social policy

Local Health System
Integration Act, 2006

Comité permanent de la politique sociale

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Thursday 2 February 2006

Jeudi 2 février 2006

The committee met at 0904 in Valhalla Inn, Thunder Bay.

LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

The Chair (Mr. Mario G. Racco): Good morning. It's lovely to be in Thunder Bay. I want to welcome in particular the local MPP from Thunder Bay, who is joining our team to hear the wishes of the people, and of course everyone. We have another long day of presentations today, probably until 6 unless there is any change.

JULES TUPKER

The Chair: We will start right away with our first presentation, and that is from Mr. Jules Tupker. There is 15 minutes time for your presentation. In any time left, there may be some comments or questions from the three groups. Please start any time you're ready.

Mr. Jules Tupker: Good morning. My name is Jules Tupker. I am a retiree in the city of Thunder Bay. I have some concerns about LHINs, and I'd like to make this presentation to you. Hopefully there will be enough time to ask some questions; we'll see how that goes. Everybody has a copy, I hope.

The Chair: Yes.

Mr. Tupker: Great.

The citizens of northwestern Ontario have for years been hoping for a provincial government in Toronto that would recognize the size of our region, the sparse population, the extreme weather conditions and the many other aspects of northwestern Ontario that make us different from southern Ontario. That hope was again revived in regard to the many problems we face in our health care services here in the northwest when the Liberal government announced it was looking at changing the way health care was going to be administered.

In November 2004, the government introduced Bill 36, the Local Health System Integration Act, 2005. The bill, as stated in the preamble, is intended to acknowledge

that "a community's health needs and priorities are best developed by the community, health care providers and the people they serve," and I believe is intended to localize the provision of health care services by allowing communities "to make decisions about their local health systems."

The bill, however, uses a southern Ontario interpretation of the word "localized." Localized health care in southern Ontario means within an area that is easily accessible or within a short driving distance. That interpretation, however, does not fit northwestern Ontario.

Again, northwestern Ontario—and I'll go into this a little bit further on—is huge in size. If you look at the size of this LHIN, it's massive compared to any other LHIN that has been proposed by the government.

In reviewing the legislation, I have discovered a number of items that cause me concern, and I will attempt to present some of those concerns today.

The local control myth: I believe that Bill 36 and its new way of managing the health care system through a number of local health initiative networks will grant very little power to the citizens, communities and health care providers of the northwest and that it is nothing more than an attempt by the Liberal government to gain more control over health care costs by merging and privatizing health care providers and to create another layer of bureaucracy that will shield the government from the public's wrath.

Bill 36 sets out that the Lieutenant Governor in Council may amalgamate, dissolve or divide a LHIN. A LHIN's board of directors "shall consist of no more than nine members appointed by the Lieutenant Governor in Council." The Lieutenant Governor in Council "shall designate one chair and at least one vice-chair." The government controls the remuneration of the LHIN's board, and each LHIN is required to sign an accountability agreement that ensures it will abide by the government's wishes. Section 36 of the act sets out the issues that the Lieutenant Governor in Council and the minister can control, and it seems quite clear to me that no matter what policies or changes the local LHIN board tries to implement, if they do not satisfy the cabinet or the minister, then they will be vetoed.

What this means to me is that the LHIN and its board of directors are mandated to carry out any plans that the government wants to propose and the LHIN will be obliged to carry out those plans or else face the possibility

of either amalgamation with another LHIN that will carry out what the government wants or face dissolution.

The LHIN cannot put forward any suggestions that would benefit the residents of northwestern Ontario if those suggestions contradict the government's vision of health care. No matter how committed the board of our local LHIN is toward ideas that would benefit the northwest, it will not be able to present or support those ideas if they contradict the government's plans. The LHIN will not be able to represent local health care needs at all.

I further believe that the legislation will stifle any possibility of objection that the citizens of northwestern Ontario have toward government policy, because any arguments that are raised will have to be dealt with by the LHIN, not the government. The LHIN will respond to any argument by claiming that it can only implement practices and policies that are in agreement with the government's vision of health care. The government will hide behind the LHIN and claim that the LHIN is implementing the practice or policy, and not the government. This LHIN model takes control of local health care issues away from the citizens of northwestern Ontario and leaves it in the hands of the government in Toronto.

I would like to point out one major event that brought northwestern Ontario together on health care and demonstrated a true example of regionalization of health care. The event was the creation of the Thunder Bay Regional Health Sciences Centre. The hospital board and the general public were instrumental in the fight to build a larger hospital in Thunder Bay than had been originally planned by the Conservative government. The expanded hospital is the result of a northwestern Ontario inspired desire and need and was not one that the government of the day was anxious to agree to. The government was pressured by the citizens of northwestern Ontario to expand its plans for the regional hospital. The successful fight undertaken by all of northwestern Ontario would have been much more difficult, if not impossible, had a LHIN board been in place at the time.

Bill 36, if implemented in its current form, will not improve northwestern Ontario's health care and may well take away any power we have in health care decisions at this time.

The Chair: Have you finished, sir?

Mr. Tupker: No, I'm not finished. Thank you.

The Chair: Sorry. I was just welcoming one of our local MPPs.

Mr. Tupker: It's nice to see him here on time. Thank you.

Loss of services and jobs: Bill 36 claims in section 15 that the LHIN will have the power to develop "an integrated health service plan" for all of northwestern Ontario and ensure that the plan must be made in the form specified by the minister and "shall be consistent with a provincial strategic plan" that will be developed by the minister.

This integration will give the LHIN the power to request a voluntary integration agreement between health service providers or other entities that may or may not be

health service providers. The LHIN, because it has control over funding of the service providers, could also force integration of services between health service providers or other entities by withholding funding from a health service provider that did not voluntarily integrate with another health service provider or entity. The LHIN also has the power to veto a voluntary integration of health service providers, to order health service providers to cease providing all or part of a service to a certain area and the power to transfer all or part of a service from one location to another.

What this means to me is that the LHIN can require a not-for-profit health service provider to transfer all or part of its services to another health service provider or, indeed, some entity that is not necessarily a health service provider at all, thus effectively terminating the operations of that not-for-profit health service provider. The legislation, however, does not allow the LHIN to close a for-profit health service provider or entity. There is nothing in the legislation that requires a surviving health service provider or entity to be in the same community as the health service provider that is being terminated. The loss of a health service provider in a community will necessitate travelling to another community for that service, and we all know the problems related to travel in northwestern Ontario.

0910

The loss of a health service in a community will also result in the loss of the jobs that service provided. As an example, the ability of the LHIN to transfer services to an entity that is not-for-profit or indeed to an entity that has no background in health services will result in layoffs and in lower-paying private sector jobs. Further, section 33 of the act will, I believe, allow non-clinical jobs in hospitals and seniors' homes, such as dietary, laundry and housekeeping services, to be transferred to private, for-profit entities outside of the communities where these institutions operate, again resulting in the layoff of workers. Communities in the northwest can ill afford any more job losses.

Anyone believing that this could not happen must be reminded that each LHIN is bound by the accountability agreement it signs with the minister that covers its performance goals and measures and a plan for spending the set amount of funding it receives from the minister. The LHIN must do everything in its power to control costs.

A further point of interest is the fact that although the act does not give a LHIN the authority to close a hospital in a community, section 36 of the act does give the Lieutenant Governor in Council the authority to exempt a LHIN from any provisions of the act. This leads me to believe that if it was decided by the LHIN that a hospital should close, the LHIN could be exempted from any restrictions in the act, allowing the LHIN to close the hospital; a worrisome thought indeed.

Increased costs: Bill 36 and the LHINs it creates will result in increased costs to the citizens of northwestern Ontario for a number of reasons. First, the possibility of

increased travel to obtain health services that are no longer in a community will not only result in a great deal of inconvenience and loss of time but will cost the citizens of northwestern Ontario a great deal of money. The government in Toronto, contrary to its constant denial, has no concept of the size of the northwest and has not taken into account the time, peril and cost of travel from one community to the next. We have an unlimited number of stories about out-of-town travel that I will not go into.

Second, the LHIN program establishes a service purchaser-service provider model that leads to the expansion of privatized services that will eventually lead to reduced services and higher costs. As an example of privatization leading to a loss of services, one need only look to the CCACs whose boards were taken over by the government because of cost overruns. The government, in its efforts to cut costs, flatlined funding and permitted the tendering of services to the lowest bidders, including private, for-profit corporations, which resulted in a deterioration of service and no cost savings in the end. Privatization of public services in Ontario has a long history of increased costs and reduced services that I will not go into. The British experience with increased costs and reduced services resulting from privatized health care is well documented.

Third, the legislation allows the LHIN to transfer health services from public, not-for-profit entities to private, for-profit entities. This would result in the transfer of health care services from a public hospital to a private, for-profit nursing home. Care in a for-profit nursing home will not be the same as in a hospital, and costs for certain services that were covered in a hospital under OHIP will have to be paid for by the patient. I have yet to find a for-profit corporation that can maintain services equivalent to those provided in a not-for-profit organization at an equivalent cost to the patient.

In conclusion, I have presented to you a few of the concerns I have with Bill 36, and I hope I have been able to convey to you some of the shortcomings I see in the legislation.

As I stated in my opening comments, we in the northwest have unique conditions that we must live with, and I believe that Bill 36, although laudable in its concept, falls short of hitting the mark in a number of areas and clearly will create more hardships than remedies for the health care of the citizens of northwestern Ontario.

Thank you for your time and consideration.

I have also included in my document, on the last page, some stuff that I was going to put into the presentation. What I did when I was putting this document together—I was reading the act, obviously, and I had some other information that I was just sort of jotting down. The things at the end are basically things I didn't put in the presentation, obviously, with the 15-minute limit, but these are issues we could talk about and that are of concern to me also.

The Chair: Thank you. We are going to allow three minutes for comments and questions. We normally start with the opposition. Mr. Arnott or Mr. Miller, please.

Mr. Norm Miller (Parry Sound–Muskoka): Thank you very much for your presentation. You obviously spent a lot of time working on it.

One of the points you made was about the myth of local control, and I think people in southern Ontario don't realize just how huge the northern LHINs are. As an example, I know the one in my riding of Parry Sound–Muskoka includes Parry Sound and James Bay. How large is your LHIN here?

Mr. Tupker: From the drawings I've seen, the actual size of the LHIN here, as far as distances go—I couldn't give you the actual area—is from Marathon to the Manitoba border, and from the international border with the United States all the way up to the top of the province. It's massive. It's huge.

Mr. Miller: And your point is that you actually have less local control. What do you think will happen to hospital boards if LHINs are brought in?

Mr. Tupker: My concern is that hospital boards will lose any power and any control they have. The actual size of the LHINs is a problem. The distances between municipalities are the other problem, and that's where I see the biggest issue is going to be. Most municipalities that are centres of health care, with hospitals or homes, are anywhere from an hour to three hours apart. I can see services being consolidated, resulting in these services closing in one municipality and being transferred to another municipality, and those people having to travel an hour to three hours to get the service they are getting now in their own municipality.

Mr. Miller: And not a local voice.

Mr. Tupker: And not a local voice; exactly.

The Chair: Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning.

Let me follow up on that point. The other concern is with services in hospitals, because there are a number of communities in northwestern Ontario that have their own small community hospital where people can go for a range of services right now; it's the same in my part of the world. For other major services, everybody has to go to Thunder Bay, and in my part of the world everybody goes to Sudbury, where I live.

Having said that, I have no interest in seeing people from Timmins, North Bay or Sault Ste. Marie driving three and four hours to obtain even more services if specialized services are located at the regional hospital. As someone from northwestern Ontario, knowing that there are a number of communities that have small hospitals where people can get service now—it's very clear that the legislation does allow for that transfer of services—what are your concerns in that regard?

Mr. Tupker: Well, obviously the concern is the distances, the time to travel and the inconvenience of having to travel to those locations. A clear example right now is that Dr. Porter used to do knee surgery in Thunder Bay, and it's ironic that it's going away. He used to do knee surgery in Thunder Bay. He's got a private clinic now in Dryden, so if anybody wants to get their knees

operated on by the best orthopaedic surgeon I know of who does knees, they have to travel to Dryden, which is three and a half hours away, to get that service. Likewise, if that service is concentrated in Dryden and some other service is opened in Thunder Bay, then people in Dryden have to come all the way to Thunder Bay for that specialized service. It's absolutely bizarre, what is going to happen.

The Chair: Ms. Wynne or Mr. Gravelle?

Mr. Michael Gravelle (Thunder Bay-Superior North): Thanks very much, Jules, for your presentation. I appreciate your concerns, very much so, and I think we share them. But certainly when I look at the Closson report, which the LHINs are being asked to implement, it speaks about enhanced services, specifically in the communities outside Thunder Bay, and I presume you are aware of that. We look at the proposed designation of Wilson Memorial in Marathon as being a district hospital, and there are others as well west of Thunder Bay, two district hospitals. So the recommendations in the Closson report, which the LHINs are being asked to implement, would certainly go against what you're saying. They are arguing and making the recommendation that we should have enhanced services in communities outside Thunder Bay.

Can you comment on that, because that's the other way of looking at it, obviously, in terms of what's out there now that the minister is working on.

Mr. Tupker: You're absolutely right, Michael. When you see the legislation, you say, "Maybe Toronto is finally going to give us some control over our health care and they're going to implement something that is going to allow the community and the whole of northwestern Ontario to look after itself." But the problem I see in the legislation is that there is an agreement that is signed by the LHINs with the government, and they are going to be allotted X number of dollars to provide that service. If at the end of the day the LHIN finds that the McCausland Hospital or the Atikokan General Hospital is too expensive and the budget for that hospital can't afford to maintain some of the services they have there, then they have to make a decision either to keep the services in that particular hospital or take the services away because they don't have enough money to afford it, and that decision will have to be made by the LHIN. The funding is controlled by the provincial government. At the end of the day, the provincial government, the minister, has control over the funding.

As I said, the intent is wonderful. I think it's great that finally we're going to have something. But when you start looking at the actual document, Michael, I have some grave concerns that, at the end of the day, the LHINs' hands are going to be tied. There is going to be some stuff that's going to be local but, at the end of the day, when the crunch comes down, some of the local hospitals, some of the local nursing homes and homes for the aged are going to suffer. Some of the services are going to suffer. A decision is going to have to be made by the LHINs that they can't afford it in that municipality

and it's going to be moved to another municipality. I'm sorry, folks, but that's the way it's going to be. Again, the legislation clearly states that we have no access to the government to make those complaints as we did—and you're very aware of what we did—with the hospital.

Mr. Gravelle: That's not the vision of the Closson report. I know we haven't got time to carry on, but I appreciate your points. Thank you.

The Chair: Thank you.

0920

NISHNAWBE ASKI NATION

The Chair: The next presentation is from the Nishnawbe Aski Nation. Alvin Fiddler and Victoria Beardy, I believe, are both on the list. Just a reminder, sir, as you take your seat, that there's a total of 15 minutes for your presentation. If there is any time available, we'll be able to ask some questions. You can start any time you're ready. Good morning.

Deputy Grand Chief Alvin Fiddler: Good morning to the members of the committee, and thank you for the opportunity to speak with you this morning. My name is Alvin Fiddler. I'm the Deputy Grand Chief for Nishnawbe Aski Nation. With me is one of our elders from Muskrat Dam. Her name is Victoria Beardy.

I'm here to speak on behalf of the 49 First Nation communities that make up Nishnawbe Aski Nation. I wanted to first of all extend my invitation to this committee to our territory. This is not our territory. I've looked at the list of communities or centres that this committee has visited or will visit. None of those are in our territory, and yet we cover two thirds of the province. I think it's only appropriate that this committee make that effort to be in one of our communities to hear directly from our people on the issue that's going to be discussed here today.

This year marks the 100th anniversary of our treaty. Of all the treaties in Canada, Treaty 9 is the only one where the province is also a signatory to a treaty. So we come before you today not as a stakeholder or part of an interest group, but as a treaty partner.

We have several concerns with what's being proposed here. There is a presentation in your package that outlines some of those concerns and some of the issues that we have with the proposed bill.

I want to say from the outset that we totally reject the bill as it stands now. There is a chiefs' resolution in your package from the 49 chiefs from Nishnawbe Aski Nation that support that. Why is that? Because we've always believed that before the signing of our treaty, our society was complete. We had our own systems, including health care. We had our own healers, our own medicines and our own way of looking after ourselves. If you look at the last 100 years, over the course of that 100 years, you will see that today, when you look at the health status of our people, we are number one in diabetes, we are number one in suicides, we are number one in cancer now. As we speak, those numbers continue to escalate.

We want to propose to you, our treaty partner in Ontario, and to Canada that we need to work together in developing a health care system that's going to work for us. We're asking you, as our partner, to help us do that.

I'm going to ask Victoria to speak to how we used to look after ourselves, how we used to heal ourselves and to maintain our health, and how we used to see our elders live longer and healthier, not the way it is today. So I'm going to ask her to speak at this time and I will translate for her.

Ms. Victoria Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: She's saying that as far as she can remember, it was very rare that our people got sick. Our people did not die of any disease or sickness. They lived to be very old and they used what was given to them by the Creator to heal themselves if they were sick and to keep themselves healthy.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: She's seen a lot of change over the course of her life. Today she sees a high number of her community members sick with diabetes, with cancer, and children as young as 10 are diagnosed with diabetes. There is also a high rate of suicides amongst our young people.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: For elders like herself, she still practices and she still uses the traditional medicines to keep herself healthy.

Twenty-five years ago she was diagnosed with diabetes, but since then she's really looked after herself, eating traditional foods and using traditional medicines, and she does not have to use insulin or give herself shots of insulin.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: Even now in her community, when people have accidents or injuries, they come to her and she provides them with medicine to heal from their wounds and from their injuries.

She wants to see our young people go back to that. She wants to ensure that our young people know that was their system a long time ago, and she wants to see our young people go back to that.

Ms. Beardy: *Remarks in Oji-Cree.*

Deputy Grand Chief Fiddler: She has heard about some of the proposed changes, that the government is planning to restructure or change the health care system, and she is very concerned about that.

That's it.

0930

The Chair: We thank you both very much for your presentation. We will allow 30 seconds each for potential comments. Madam Martel, would you like to start?

Ms. Martel: Meegwetch, Deputy Grand Chief. Meegwetch, Elder Victoria.

I'll probably just make a comment. Yours is not the first presentation we have heard from aboriginal people to express grave concern about the process, or lack of process, that was in place with respect to this bill. In the case of Treaty 9, it's even more distressing, because you

are right: You are a partner, not a stakeholder. There should have been a full and comprehensive process of consultation and negotiation with First Nations, particularly with Treaty 9, with respect to health care. The government says now, after the fact, that they are looking at a report with respect to aboriginal health care. That will be released at some point, and we will see where the government intends to go. But I think it is regrettable, especially in light of the announcement the government made this summer that there would be a new relationship between the government of Ontario and aboriginal people, that the government should have proceeded in the way it did with Bill 36, without any consultation with First Nations people. So I hope that from here on in, the process of consultation and negotiation with aboriginal people, and with Treaty 9 in particular, will be much different and will result in a plan where your health care needs can be met and respected.

The Chair: Thank you. Mr. Mauro, please.

Mr. Bill Mauro (Thunder Bay-Atikokan): Thank you, Deputy Grand Chief, for your presentation.

It's my understanding, and I'm curious if you're aware, that the minister is currently engaged in a process of discussion with First Nations groups to try to address the concerns that they're presenting, as indicated in the legislation. I'm wondering if you're aware of it, first of all, and if you are satisfied with what's being presented to address your concerns.

Before you get a chance to answer—I don't think I'll have a chance for another question—I'd really be interested to know what is going on to address diabetes without having to use insulin. I'd be very interested in that, as an aside, if you could address that question.

Deputy Grand Chief Fiddler: Thank you for the question, Mr. Mauro. Yes, I am aware that the minister agreed to establish a First Nations task force this summer to look at the impacts of LHINs. There was a limited time frame to do that. My concern was—and I told the minister this—that it's very difficult to assess something that has not been fully established yet, that is not fully functional. I agreed to be a part of that, not because I totally believed that this was going to be the vehicle to make a difference, but I agreed to join the task force out of goodwill. I think the concerns remain that even with the recommendations in that report, there is no guarantee, there is no assurance that those will be incorporated in any bill or in any system.

The Chair: Mr. Miller, please.

Mr. Miller: Thank you very much, Deputy Grand Chief and Victoria, for your presentation today.

Your point right at the very beginning: You were saying that you had hoped the committee would go to your traditional lands for a meeting. I just wanted to make the point that I did speak with John Beaucage. He called me about that and asked me if the committee would go to Garden River, I believe it was. I did write to the Chair requesting that on your behalf. I just wanted to make that point.

Thank you for your presentation today. I look forward to other presentations.

Deputy Grand Chief Fiddler: Can I just clarify his comment?

The Chair: Yes.

Deputy Grand Chief Fiddler: John Beaucage is the grand chief of the union. That's a different PTO.

Mr. Miller: I understand that.

Deputy Grand Chief Fiddler: That is more northerly—northeast, northwest.

Mr. Miller: I'm familiar with that. John Beaucage is from my own riding. He's originally from Wasauksing First Nation. I know him, so I think that's probably why he called me just to make that request. I did write to the Chair requesting that we have a meeting.

The Chair: Thank you again for your presentation. Have a lovely day.

RED ROCK INDIAN BAND

The Chair: The next presentation is from the Red Rock Indian Band, Harold Sault, councillor. Good morning.

Mr. Harold Sault: Good morning, sir. I'm kind of caught off guard here. I thought I was doing something totally different.

The Chair: You have 15 minutes to present your case.

Mr. Sault: Pardon me?

The Chair: You have 15 minutes to present your case as you please. If there is any time left, we may ask questions or make some statements. It's up to you.

Mr. Sault: Absolutely, yes.

First, I'd like to comment that when I come in, I don't see many of our First Nations people in here at all. I'm wondering how this meeting was set up.

I'm going to give a little history of what I see so far, as a First Nations person, how this started to unfold, in my mind, and when we came across this.

Where there are forms to sign regarding grant permission, I think they tried to pass that behind us without our notice. When we do stand up and notice, this bill seems to be crammed down our throats. To me, that doesn't show much faith in working together and trying to come up with something.

It overwhelms me to think that in this day and age these kinds of tactics are still coming from the government, I guess, or whoever is trying to cram this down our throats. There are so many issues. I know most of you, anyway, should have read the dialogue that was being sent back and forth between the Union of Ontario Indians and yourselves—the government. Pardon me. Like I said, I'm not even sure what's—it's so explanatory in this, but there are also other issues.

You can see that this bill they're trying to pass on us is riddled with genocide. It doesn't give us any strength. It doesn't give us any options. All it does, what I read of it—and I read the letters going back and forth—it's losing for us all the time; again, losing, losing. We're losing in every aspect from every department of the government, like INAC and Ministry of Natural Resources and so on.

We were told that we didn't have to sign a consent form and that it was an option to us. If this is an option, how can you call it an option if you're going to have a person with bills that may run into the tens of thousands of dollars pay for it and then expect to send a bill to the government? That's your option if you don't sign this health form.

There are so many things—our loss of services and programs. It sure is a clear map towards that. It's a clear map to losing our rights, our rights that I thought were protected in this day and age. I've heard of court case after court case winning, entrenching our rights, giving the obligation to the government to consult with our people. This hasn't happened at all during the passage of the bill. Like I said, it just shows me the faith we have in each other. First Nations people have been trying to work, broker, deal—everything—to try to get something to work with the government. It's obvious that that's not the trail that wants to be taken.

I honestly believe that our leaders in the higher places should be organizing a lawsuit on the fact of genocide. It might not be with just the health division; it's with everything. Our traditional practices are being eradicated, erased, wiped right out in our areas. That's more of where I am right now. Like I said, this ain't my portfolio, but there are a couple of people who have heard me before—I can talk.

0940

These areas where we're losing our rights are keeping us down—the poverty on our reserves and stuff like that. When you have a bill like this, that is a blackmail—if you read this, it's blackmail, when you have to sign it or you have to wait. It gives the power to the government to start erasing our rights. We see that happening so much lately, you know, in the last few years, time and time again. Our people are financially limited. They can't afford to buy their medications outright and have it repaid.

I'm trying to look at my stuff I was writing on the drive up here. It reminds me a lot of times of when you were 16 years old and you went to get your licence. You're always told by somebody that it's not your right, it's your privilege to drive; it is a privilege to you. First Nations people have a right. We have that right. We have a right in deciding our own future. We have a right as a nation. We were organized before. We're organized now—semi—and we have that right to work on deals or negotiate, like with this situation here. When you take that right away and you force this signing on us—the first time I saw this consent form thing, I saw an elderly lady dressed in what you would say is First Nation clothing or whatever, all smiling, signing this consent form. It shows how we are still being treated.

Numbers come out that First Nations people are starting to vote more and more and more. I see from the Canadian government flyers, again, three people; it doesn't say anything about First Nations or whatever. But the three people on the cover—and this is from the government—are First Nations people. I see all this stuff in the media that is giving the impression to our people

that we have this relationship that we're building, better and better. I will be the first guy to argue that point, but I also will support the people within the government—and I know there are a lot of them—who do work for First Nations people. But if they don't have a voice—it's like this train that's coming and you can't stop it, and this is one of them. We're losing in so many different areas that we have to stand up for this.

I'd like to say right now that if this comes down to signing a consent form, I will not do it myself. I will urge all our people not to do it. What I will urge is that for this bill that wants to be passed, or however that's going to take place after today, we work on it together and try to come up with some sort of reasonable deal with each other.

I can get into these letters, and I'm sure you've read them. I've read a lot of these issues, and they've been said time and time again. There's not much more to add to it, except that a lot of factors were left out of this. There are a lot of things that should be looked at: the future, what's going to happen. I do believe this bill is a step towards the loss of our rights, further and further, and I will not support it and I will not stand for it.

I don't know if there are any questions.

The Chair: We have about a minute and a half available for questioning. We'll start with the Liberals this time. Ms. Wynne, 30 seconds.

Ms. Wynne: Thanks for coming this morning. I just wanted to pick up—I think the consent form may be part of another process. Maybe we can talk about that afterwards.

As far as this bill goes, the conversation that's going on between the minister and First Nations, what we're expecting—and I just want you to know this—on the committee is that there will be an amendment to the legislation that will actually go some way to addressing the issues that have gone back and forth in those letters you're reading and that, you're right, we have all seen. I don't know exactly what the nature of the amendment is going to be, but the changes the minister is talking about with the First Nations groups are going to address those concerns. It is our expectation. You said that you think we should be working on it together. I completely agree with you, and that's why the minister has been meeting with the First Nations to come up with a change to this legislation. I hope by the time it's ready to get passed, you'll be able to support it.

The Chair: Thank you.

Mr. Sault: I'd like to comment on that. It's like shooting a bullet at somebody: You can't stop it. You're forcing this upon us and then you say, "We're going to force this on you and then we'll talk about working it out later." You're saying there's going to be an amendment to the bill?

Ms. Wynne: Before it passes, yes.

Mr. Sault: Before it passes? So it's passing?

Ms. Wynne: It hasn't passed yet.

Mr. Sault: No. But that's my point: The push is on to pass this bill. It's hard for us to pass this bill, for me to

say, "Okay, pass it, and now we're going to talk; then we'll start talking within it." Is that what you were saying: the amendment?

Ms. Wynne: No. The amendment comes before the bill even gets passed.

Mr. Sault: I understand that.

Ms. Wynne: So the conversation is happening now, and then the bill goes back to the Legislature with the change already in it and gets passed in that way.

Mr. Sault: My point is, and you can correct me if you want, but once this bill passes, everything that's in it is also passed. Correct?

Ms. Wynne: True, but we're talking—

Mr. Sault: That's right. Everything in this bill is already passed, so the area—

Ms. Wynne: No. Not yet.

Mr. Sault: Okay, I'm sorry. If this is passed, the bill—

The Chair: Mr. Sault, if I can be of assistance: The groups we are meeting here today, and everybody else, that is to hear what you have to say and suggest to us any change that you want, which you are doing right now, and supposedly—I can't guarantee that—your suggestion and other suggestions will be incorporated. I think that's what you have been told.

Mr. Sault: Scrap the bill.

The Chair: You did a good job by telling us what concerns you have. Hopefully, we'll be able to address them before the final reading. But I'm sure the other parties may want to add something to that when it's their turn.

Mr. Sault: If that's what you want to hear from me, I'll tell you: Scrap the bill and start from scratch with First Nations people. That's basically it. There's too much genocide in this. It's directed toward genocide.

The Chair: Mr. Arnott.

Mr. Ted Arnott (Waterloo-Wellington): On behalf of the Progressive Conservative Party of Ontario, I want to thank you for making your presentation today. Our party shares many of the concerns we've heard over the course of the last few days of hearings. We have heard from a number of First Nations organizations that there was completely inadequate—nonexistent consultation in some cases. I was pleased to hear the parliamentary assistant to the minister just now acknowledge that and indicate that there is consideration being given to amendments. I think that's the first we've heard of that so far. I think you should be encouraged by that, but at the same time continue with the persistent points that you've been making. You're absolutely right: The government is very determined to pass this Bill 36 in some form. In fact, they put the cart before the horse by setting up the local health integration networks, by appointing CEOs at very high salaries, and boards all across the province, before they even had the legislation in place; in other words, the legal authority to do it. I think we have to continue to be very vigilant on some of those issues. Your participation today has been very helpful in that respect.

Mr. Sault: Thank you. I also would like to add—I know my time probably ran out—that I would ask every-

body here to please not consider this as consultation. I was asked to come and speak my mind. As you know, this is not a consultation, so please don't consider it as that. Thank you.

The Chair: Ms. Martel.

Ms. Martel: Thank you very much for having been here to give your opinion, to speak your mind today. We appreciate that and we understand, or I understand, that this is not consultation in any way, shape or form as would be understood or accepted by aboriginal people generally, and by yourself specifically. I think the point that has to be made is that there was no consultation with aboriginal people with respect to this document. There wasn't and, frankly, the way to resolve this is to put forward an amendment that would exempt aboriginal people from the provisions of this bill and then, as you said, start a full and fulsome dialogue, consultation, negotiation, with First Nations about what is necessary to meet the needs of First Nations people with respect to health care.

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I don't know what the minister is going to do in this regard. What I have seen is a lot of work after the fact; that is, after the bill was presented and First Nations reacted negatively to it. Then we started to see some consultation in a meaningful way about what to do next. That process should have happened before the bill was ever introduced and I regret that it did not. We hope there will be a process that will truly recognize First Nations as partners and we hope we will see that unfold in the near future.

I wanted to ask about the more specific health care concerns you bring today with respect to your own community. I'm assuming that diabetes is a very large problem in the community, but perhaps you'd like to tell us some of the key health issues that need to be addressed in your community.

Mr. Sault: I feel the health issues have been spoken about so many times. Coming from my mouth, I'm not sure it's going to change anything. Our health concerns in our community, of course, are the diabetes and alcoholism. There are numerous problems that our community shares with other communities, and with non-native communities. Our biggest problem, when it comes to how it appears to me this is going to work, is being forced to sign a consent form. I understand that if this consent form part is taken out, fine—well, not “fine”; pardon me.

It's a financial problem now, a financial burden. If you want to go and keep doing what you have to do, you have to sign a card that says we recognize you to do it, but in doing that, we also cannot recognize you if we want. That's one of the big issues, that a lot of people like myself, who are stubborn, to help in the control of the future of our people, will not sign this. A lot of them are elderly people. It is a very big health risk when they can't get the medication they want.

The Chair: Thank you very much for your comments.

Ms. Wynne: On a point of order, Mr. Chair: I just want to put on the record that the Speaker of the House

ruled in May that there was no contempt of the Legislature in the setting up of the LHIN boards in advance of this legislation. I just wanted to make that point.

The Chair: Thank you very much.

TREATY 3 NATION

The Chair: The next presentation is going to be a teleconference with the Treaty 3 Nation. We have Simon Fobister, Deputy Grand Chief. Are you on the line, sir?

Deputy Grand Chief Simon Fobister: Yes, I am.

The Chair: Please proceed with your presentation, sir. You have 15 minutes.

Deputy Grand Chief Fobister: Good morning, ladies and gentlemen. I've been recently appointed as a Deputy Grand Chief for Grand Council Treaty 3. We represent 17,500 stakeholders from our Treaty 3 Nishnawbe Nation. We have deep concerns with Bill 36, the Local Health System Integration Act. I want to cut to the chase and go right to the presentation.

This is Grand Council Treaty 3's position on this bill. While Treaty 3 is in general agreement with the objectives of the task force recommendations, it recognizes that the forum for achieving many of these goals may not be the LHINs and that a more pragmatic approach may provide more common ground for our discussions.

We are also concerned that by asking for an exemption from the LHINs, any of the meagre funded and staffed programs etc. that would be used for aboriginal programs or for work in First Nations communities will be given to other programs or services in non-aboriginal communities. When it comes time to provide services to our community, we again hear that funds have been allocated elsewhere or that no funds exist. We do not want to have to wait for years to catch up to the level of services that other, non-aboriginal communities have. A look at the terms of reference for the task force will give a common framework for our discussion.

We would place the role of Health Canada at the top of our priorities, as the First Nations and Inuit health branch of Health Canada is the delivery agent, provider of funds, programmer and partner in the health care we receive in our communities and for our membership. Their participation in any discussion concerning health care networking is extremely important. Many of our communities have different and complex relationships with the First Nations and Inuit health branch. These range from government staff providing services, to the delivery of defined services through a yearly contribution agreement, to the provision of services through a five-year transfer agreement and to the potential of services provided through self-government agreements.

Under these circumstances, Bill 36 may provide some positive opportunities for communities, yet cause negative results in most other communities. This wide variation should indicate to Ontario that aboriginal people will not benefit from a single solution to this issue.

On that note, I further indicate that the area covered by LHIN 14 will provide more complications for health

planning and delivery. We have isolated, rural, and urban communities within these boundaries. The number, size and population of the isolated, semi-isolated and rural aboriginal communities can skew the health care delivery system. I'd also point out that the limited aboriginal representation anticipated for the board of directors of the agencies will not allow for proper community input into the planning and delivery of programs and services.

The patchwork of service delivery and programming that exists in First Nations communities requires that all levels of government work together to ensure that not one of our people falls through the cracks in the system. If it is our desire to ensure that this does not happen, then an approach that is aboriginal-specific must be developed to meet the needs of First Nations, Canada and Ontario.

Governance and accountability: The issues raised above also impact on the design and implementation of the LHINs. First Nations cannot agree to the delivery of services that may reduce both treaty and fiduciary responsibilities that the federal government has. The provinces have never wanted to take on these roles, and it seems that the current desire to have the LHINs provide services to First Nations may put Ontario in the position of taking on treaty and fiduciary roles and responsibilities.

Health system planning and evaluation, service delivery coordination and integration, and human resources staffing and requirements: Again, these issues require that all health delivery agencies, as well as Indian Affairs, Human Resources Canada, universities, colleges, education and training departments, etc. sit down together to plan for the future integrated health care delivery system.

Aboriginal health programs: We would like to reiterate the position that we are not mere stakeholders in the health care system. As treaty aboriginal people, we have aboriginal rights relating to health and treaty rights to health and are a fiduciary of the federal government. This provides us with special status when it comes to health care programming and to the whole issue of self-government and self-determination in relation to health care. We cannot enter into a relationship with the LHIN while these issues are swept under the carpet and both the federal and provincial governments try to act like they do not exist.

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I would now like to set out a series of recommendations that Treaty 3 sees as necessary if we are able to proceed beyond our current situation. The recommendations are as follows:

(1) For a truly integrated health planning, delivery and funding system, First Nations, federal and provincial health departments must sit down together and form a real partnership to provide better integrated health services to our community.

(2) There must be a non-derogation clause in the legislation, or stated in some manner, in order to address the aboriginal treaty and fiduciary rights issues. This requires direct consultation with First Nations.

(3) For LHIN 14, the board of directors must be expanded to ensure that an appropriate mix of isolated, semi-isolated and rural aboriginal points of view are represented.

(4) That funds for new or additional programs, services and staff, as well as the current levels, be protected or set aside for aboriginal communities while discussions are ongoing.

This ends my presentation. I'd like to thank you for taking the time to listen to our concerns.

The Chair: Thank you for your presentation. There's 30 seconds for each group to ask questions. I'll start with Mr. Arnott or Mr. Miller.

Mr. Arnott: Thank you very much for your presentation. We do appreciate the advice that you've given the committee. It's important that you've had the opportunity to participate in this consultation, because we're in the process of continuing our public hearings for the next few days, and then, hopefully, the government will be coming forward with amendments. Certainly our party will be doing the same and hoping that we can improve this bill to ensure that it's in the best interests of First Nations and all Ontarians.

The Chair: Ms. Martel.

Ms. Martel: Meegwetich. Deputy Grand Chief, congratulations on your new role as Deputy Grand Chief in Treaty 3. I have written down the recommendations, but I would ask for clarification on one point. You want a non-derogation clause in the bill, which of course would then ensure respect of treaty rights. Would Treaty 3 also want an amendment that would exempt Treaty 3 and other First Nations from the bill as well, to be absolutely clear that nothing will happen with respect to First Nations health care services unless and until there is a better consultation process to arrive at what those services are?

Deputy Grand Chief Fobister: Yes.

Ms. Martel: So both would be required, then: a non-derogation clause and a second clause to exempt First Nations, urban and on-reserve, from the bill?

Deputy Grand Chief Fobister: Yes.

Ms. Martel: Thank you very much for your participation.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you, Deputy Grand Chief, for joining us this morning. I just wanted to clarify and reassure you that I know that a number of the issues that you've raised—in fact, all of them that you've raised—have been raised with the minister when Minister Smitherman started meeting with First Nation groups as long as a year ago, February 10, 2005, and he's met a number of times since then. In April 2005, the decision was made to create a task force. The recommendations that have gone to him include many of the comments that you have raised.

On the issue of the federal delivery of services, the LHINs—the new organizations—will not be directly delivering services, so those relationships with the federal government won't change. I take your point about the federal and provincial governments needing to sit

together. Are you satisfied that the recommendations that have gone forth to the minister are ones that you can support, the ones that went forth from the First Nations task force?

Deputy Grand Chief Fobister: I just want to add that I'm new to the file, so I don't really know what occurred previously and I don't know what position papers were given to the minister. I really can't comment on that.

Ms. Wynne: That's fine. Thank you very much for joining us.

CANADIAN HEARING SOCIETY, THUNDER BAY

The Chair: We'll move to the next presentation: the Canadian Hearing Society, Thunder Bay; Nancy Frost and Carolyn High. Good morning.

Ms. Nancy Frost: Good morning.

The Chair: You can start any time.

Ms. Frost: My name is Nancy Frost. I am the regional director of the Canadian Hearing Society, Thunder Bay region, and with me is Carolyn High, who is a director of our provincial board, as well as a member of our community development board for the Thunder Bay region.

I'd like to start by saying that the Canadian Hearing Society is a non-profit agency that provides a wide range of services that enhance the independence of persons with hearing loss or who are culturally deaf. We support the concepts and basic philosophies of the LHINs, those being accessibility, coordinated services, consumer focus, community-based promotion of wellness, independence and aging in place, as they are in keeping with the philosophy and approach of the Canadian Hearing Society.

Before Carolyn can highlight what health care must look like and what the LHIN must have in place, I'm going to spend a bit of time covering who the individuals are that we're talking about: Who are they, and what does accessibility mean to them?

Hearing loss is the largest and fastest-growing disability in North America. The two main causes of hearing loss are aging and noise. Thus, in this region, under the LHIN 14, with high industry, a large aging population, a large aboriginal population, we're seeing that we far surpass the national average of 23% of the population. We're looking currently at about 25.5% of persons under the LHIN 14 who experience some degree of hearing loss or are culturally deaf. This percentage is going to continue to increase as the aging population increases.

Persons who have hearing loss or are culturally deaf, again, represent the largest disability group that requires accommodation. Individuals who are affected by these issues are not homogeneous, and they can be seen or identified as four distinct groups, one being culturally deaf: They are members of a linguistic, cultural minority group. They are not persons with a disability. Their language is a visual, gestural, three-dimensional language, and they are of a deaf culture.

The other three groups I mentioned—hard of hearing, late deafened, and oral deaf—all rely on spoken language as a communication mode, and they use a whole host of communication supports from various devices to hearing aids, note-taking, real-time captioning. I think it's really important that you fully understand the individuals we're talking about, that they've got very unique needs, very unique requirements for different accessibility options.

The next page you've been presented with has statistics, which I briefly covered, in northwestern Ontario. You have them in front of you, so I won't take time now.

What I want to take time on is really talking about accessibility for these individuals. In the current LHIN legislation, access is taken to mean ease of geographic access to services or making appropriate services available in the local community. To the 25.5% of individuals who have hearing loss or are culturally deaf under the LHIN 14, access means far more than this. It means the removal and the prevention of barriers—communication barriers. It often, we find, is a hard concept to appreciate, so I've provided a definition of "accessibility" on another page.

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Access in any service, and in particular health care, must mean not only the ability to know where services are, to be able to enter a service, but also the ability to obtain or make use of, to be able to communicate. That means ensuring that an interpreter is booked, ensuring that there's a note taker, ensuring that you've got visual fire alarm systems, that nursing staff take the time to face a person, to use pen and paper, to ensure that the person is fully comprehending what is being said. Without that full access, you're not going to get full participation. A patient is not going to understand what's being asked of them. They are not going to be able to participate in their diagnosis or in their health care or treatment.

At this point I'm going to pass it on to Carolyn, who's going to elaborate on health care and the expectations of consumers.

Ms. Carolyn High: I would like to thank the LHINs standing committee for the opportunity to make this presentation. The focus in this portion of the presentation is health care expectations of culturally deaf and hard-of-hearing consumers.

The first point I'd like to relate to you is the duty of accommodation. It is a right of health care consumers to expect barrier-free access to health care. This means appropriate accommodations to be made to allow consumer understanding and participation in an integrated fashion. The onus is on the service provider, not the consumer, to automatically provide accommodations at the entry level and systematically apply them throughout the delivery of the health care.

Effective communication and accessibility are a legal right established by the Eldridge decision in 1997 in British Columbia. Being able to communicate your symptoms or your medical history and being able to understand what is being said by service providers are imperative to effective health care. This is also a legis-

lated right as described in the Accessibility for Ontarians with Disabilities Act, 2005.

Culturally deaf and hard-of-hearing consumers require communication supports, whether it be ASL interpreters, real-time captioners, note takers, flexibility in scheduling or whatever, to truly have adequate health care.

There also needs to be a provision of equitable health care. Only by providing a barrier-free accessible environment can persons with a communication disability achieve equitable health care. There is also a need for equitable health care between the 14 LHINs. This may require provincial standards or a health care consumer bill of rights to ensure that accessibility for disability groups is enshrined into the everyday practices of health care providers.

There is also a need to develop a holistic, integrated, one-stop-shop approach to hearing health care that is consumer friendly and accountable. Recognition of community-based services should be incorporated into this model, building on present unique community strengths and knowledge of consumer needs.

At present, health care is time-consuming and costly, involving physicians, ENTs, audiologists, hearing aid dispensers and hearing counsellors. A consumer must navigate a very fragmented system over a period of months with little or no follow-up. An integrated system using qualified professionals which builds on the strengths of community-based services would provide a seamless, consumer-centred model.

It is also cost-effective to foster independent living, reducing the burden on hospitals and long-term-care facilities. Hearing care counsellors are an integral component allowing individuals to live independently in their homes. They can help modify the home environment and provide information on communications strategies as well as provide information on technical assistive devices, which might include visual smoke detectors or amplified or voice carry-over phones, TTYs etc. In addition, hearing care counsellors and deaf counsellors can provide follow-up for hearing aid devices and provide information for family members.

To enhance independent living, there needs to be an increase in public funding assistance for persons on fixed incomes, particularly seniors. At present, only a portion of the cost of hearing aids is subsidized. This needs to be extended to other assistive devices. In addition, OHIP funding needs to be reinstated for audiologists. There is a safety factor if a senior leaves their door open because they cannot afford a visual doorbell. It is a safety factor if a deaf or hard-of-hearing individual does not have a visual smoke detector.

Another issue in the north is the shortage of ENTs, audiologists, ASL interpreters, real-time captioners and note takers. We need to attract, train and make the best use of our resources by using a more integrated approach.

We need to make sure that we develop qualification standards for our professionals in the hearing care area and to maybe use different strategies like incorporating centralized video conferencing technology; for example, the NORTH Network at our hospital here. Presently CHS

uses the NORTH Network and the Smart Systems, where they can have interpreters and real-time captioners and note takers centralized who can reach out to rural areas.

There's also a need for systematic sensitivity training for health care providers. The training must be adequately funded, mandatory and ongoing, with the involvement of consumer groups.

Another area that is important is the involvement of consumers at the development, planning, audit process, advisory capacity and eventually, in time, within the LHINs board. It's important to integrate and work on the strengths of community-based service groups in the provision of the model.

In conclusion, the ideal health care system is consumer-friendly, has integrated access, is time-efficient and affordable, with appropriate entry services and follow-ups. It would have a holistic focus, including preventive health care and maximizing effective health care practices. If a person with a communication need is not accommodated, the chances are that he or she may be misdiagnosed. For example, a senior with a hearing loss may be diagnosed as having dementia and placed in a long-term-care facility. It is cost-effective for service providers to get it right from the beginning in making sure the health care system is truly accessible.

We basically support the philosophy of the LHINs. We want to ensure that the system is accessible to people with disabilities in general and to those who are culturally deaf, oral deaf, deafened and hard of hearing specifically. We are able to help the LHINs and the ministry through the provision of training. We want to be sure that the Ministry of Health understands the unique needs and requirements of our populations for specialized services. We want to be sure that the Ministry of Health understands the unique financial and administrative issues faced by the voluntary sector. The legislation must speak to the issues of public interest, due process and public consultation. The legislation must address the issues of provincial programs, agencies and their interface with local providers. We want the ministry to consider hearing loss and deafness as a priority issue with province-wide attention.

We'd like to thank you very much. If there are any questions for Nancy or myself—

The Chair: There is no time for questions, but we thank you very much for your presentation.

1020

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 710

The Chair: The next presentation is from the Ontario Public Service Employees Union, Local 710, Thunder Bay. Brenda Clapp is the president. Good morning.

Ms. Brenda Clapp: Good morning. I'd just like to mention that I've given Madam Clerk copies of this presentation for the panel here. I'd like to also make another comment: if I could have for myself and for any other presenters the full attention of the people who are here.

Sometimes it's very distracting when there are side conversations happening. Thanks.

I'd like to say hello and good morning to everyone. I'm very glad to be here today and to have been given this opportunity to voice concerns regarding the LHINs, better known as local health integration networks. This group, which is comprised of 14 regional boards throughout our province, are appointed; they are not elected. Also, the LHINs have very little or no medical background.

Before going any further, I would like to introduce myself and just share a little bit of my history with you. My name is Brenda Clapp. I am employed with the Ministry of the Attorney General. I have spent the past 27 years working in the offices of the Superior Court of Justice. Also, during these 27 years, I have been a proud and active unionist with the Ontario Public Service Employees Union. Currently, I hold an elected position on my local's executive as president of Local 710. I will say strong and proudly to you that OPSEU has worked intensely to ensure that the best public services possible have been provided to the people of Ontario, such as excellence in health care.

Throughout this time I have witnessed many changes; none, however, so radical and so far-reaching to the wellbeing of the people within our communities. As you can determine, I am not a health care worker but I am here today to lend my full support to the Ontario Health Coalition, to ONA, to CUPE, to SEIU and to OPSEU in their joint endeavours to preserve and enhance an already viable health care system. These four unions represent approximately 200,000 health care workers and are prepared to fight the LHINs. These four unions are speaking on behalf of the people of Ontario as the documents of the LHINs that have been proposed have been rushed through two readings at the Legislature without any consultation with Ontarians.

Our health care system is second to none, and is recognized around the globe as one of the best, if not the best, in the world. Hospitals in the communities deliver a universal level of health care. It is believed that Bill 36 will allow the LHINs to close many community hospitals and organize medical services somewhere outside our present community. Our present health care system does not discriminate who you are, what you are, and it especially doesn't discriminate where you are in Ontario when you need medical care. All people are given quality medical attention in our hospitals because it is available in communities across our province.

I ask just for a moment that you focus on the word "authority." This can mean many things to many people. An example of an authority can be when lights in an aircraft go on, telling you to stay seated and do up seat belts. This authority comes from the pilot. He is there to keep you and me safe. Another example of an authority could be a parent setting an 11 p.m. curfew for a teenager. This authority is there to keep the teenager safe. Now I ask, who is the authority with LHINs? The LHINs are appointed; they are not elected democratically. Who will ensure that Ontarians are safe and will have access to

multiple medical services now being offered in our communities within our hospitals?

LHINs are aiming to allow health care providers to bid low for services. Is this what we want our health care system to become: bid for profit? Providers of these services will cut corners, they will try to reduce their costs, and the care that you and I receive will definitely suffer. The quality of health care will diminish, hospitals may close, and services now available within these hospitals will be severed and transferred, causing negative effects across this province and in our communities. Bill 36, "integration of the local system for the delivery of health services," is mainly comprised of grey areas with absolutely no successful model to compare to.

Local health integration networks are moving toward having only specific services available at very specific hospitals. They are already speaking of hip replacement surgery and cataract surgery being in specific locations within Ontario.

Because so many of us have had cancer or have had family members with cancer, I will use the oncology unit and the cancer treatment centre at the Thunder Bay Regional Hospital as my example to you in an attempt to localize the devastation the LHINs plan can cause those of us living in northwestern Ontario. The oncology unit at the Thunder Bay Regional Hospital is where people go to receive medical treatment after cancer surgery or recovery from cancer. Many patients return to the hospital after chemotherapy and radiation therapy because of the many ill side effects. Once the patients go home, they can now contact the doctors and nurses at the oncology or cancer treatment centre via telephone for personal consultation regarding their ongoing health issues.

Now the big question is, if the LHINs decide that the oncology unit or the cancer treatment centre at the Thunder Bay Regional Hospital should relocate to another site in Ontario, what would this mean to our patients, to their families and to the health care workers who provide these life-saving services? Many of our patients would incur a great financial burden: the expense of travelling, such as making flights to another community for health care, accommodation while away from home, such as hotels or motels to stay at, meals, and don't forget the time off work for the family member who has to care for the patient as well. This, my friends, undoubtedly creates a two-tier health care system. If you can pay for health care services, you will receive them.

Now, for the workers, the LHINs scheme would mean reapplying for jobs when a new employer takes over. There are no guarantees that you keep your benefits or your pension. There is no job security. This would certainly lead to other economic losses and deter other health care workers from locating in our communities.

The boards have been ordered to merge, transfer and combine services. If the LHINs don't do what has been mandated to them, the government simply moves in and does the job itself. This definitely indicates that services, as well as jobs, as we now know them will be disappearing.

In view of the fact that my background is with the Superior Court of Justice, I will touch on some of the factors that apply to the court system. These facts were noted in the documents labelled "Health Law" put together by the law firm of Cassels Brock and Blackwell. "Health service providers could request the reconsideration of LHINs' integration decisions and minister's orders within 30 days of receiving the decision." LHINs and the minister could enforce integration decisions and ministerial orders by applying to the Superior Court of Justice for an order directing the party to the integration order to comply. It is believed that these orders will allow the LHINs and hospital service providers the ability to override existing collective agreements.

Our collective agreements protect our jobs, they protect our members, they protect public services and they have ensured a safe health care system for all Ontarians to enjoy.

I have spoken to many people I know and to numerous people in my union. The message I have put out is that it is time to get involved. It is time to speak to your local MPP. It is time to tell others about the LHINs and write letters to the editor. We Ontarians can no longer trust the McGuinty government to protect our health care system.

The Chair: There is about a minute left. We'll make it 30 seconds each for questions. We'll start with Mr. Mauro.

1030

Mr. Mauro: Thank you, Brenda and John, for the presentation. As a northern member—Michael and I have had an opportunity to talk about this—obviously health care has been chronically a very serious issue for people who live in northern Ontario in terms of access to services, quality of service and the cost involved in accessing that service. So we take very seriously when concerns are presented from anyone about legislation that may erode what we think already is a very difficult service provision situation right now.

Clearly, from the list of presenters, there is a lot of agreement among the different union groups represented here today that there are concerns with this. My question to you and to John, whoever would prefer to answer it, is if you could give me examples of powers or authorities that the LHIN legislation is going to put in place or give to them that presently do not already exist within the Ministry of Health that could potentially make it worse than it already is. Because my read on it is that there's nothing being transferred to the LHIN that the ministry can't already do, whether it's an integration or a hospital closure or a privatization. I'm trying to find some examples of things they'll be able to do that don't currently exist.

Mr. John O'Brien: First off, Bill, this legislation, in our opinion, should be scrapped and you should start over—I think some of the First Nations people already indicated that—because you haven't consulted with anybody. It's already had second reading. So it's totally a lack of planning. What you're doing is putting the cart before the horse. These LHINs have already been put in

place. For example, you have the chairs, you have the CEOs already appointed. There's no transparency. You're going to turn over \$21 billion of taxpayers' money to 14 LHIN groups across the province to distribute taxpayers' dollars as they see fit. There are requirements that the LHINs have to do certain things, and if they don't do certain things the Minister of Health will step in and make sure they're done. That's going to really devastate our area in northwestern Ontario.

I'd like to bring up in regard to that the current situation in northwestern Ontario with the forest industry, where it's taking away from the smaller communities, feeding the bigger communities. In regard to health care, we see that happening in the northwest too. For example, hospitals in Red Lake, Sioux Lookout, Dryden, Marathon, Nipigon could actually be closed over the next 10 years, based on this cheap type of service when you shop out information.

I guess we're out of time.

The Chair: You will have more opportunity. Mr. Miller.

Mr. Miller: Thank you for your presentation. I'll follow up on the one point you were making about the process, the cart-before-the-horse aspect of this. I know that in my area I've already met with the hired CEO for the LHIN that represents Parry Sound—Muskoka, yet the legislation has not passed. The government appointed the boards and hired the staff and the legislation is just midway through the legislative process, which does seem to be putting the cart before the horse.

You raised the point several times about the fact that the boards are appointed, not elected. So I assume that means you'd rather, if this bill passes, or an amended version of it, see the boards elected. Do you have any advice on how that should happen?

Mr. O'Brien: I think you're right on. The legislation has had second reading and is now going for third reading as early as March. You've put into position high-paying jobs, you've announced closures of Ministry of Health offices that are going to put 300 people out of work, you've got the LHINs in place, and the legislation and the authority hasn't even been passed. So it's totally ludicrous to think that now you're coming out to consult. This is crazy. You're supposed to consult before you put the stuff before the Legislature. We're asking your committee to go back to the drawing board, kill this legislation, do your consultation—because you're doing it now.

It needs to be in a lot more than four communities in this province. We have over 500 municipalities that are going to be affected by this legislation and you're going to have four cities where you're going to talk to people? That's crazy. If you saw the first presenter this morning, from Treaty 9 in the Kenora area, you're not even going anywhere near that place. Your committee is not going there. You're coming to Thunder Bay for one day and then you've got three other cities, and that's it. And they call that consultation? I can tell you, the general public, in fact your own MPPs in our area here, had no idea what

LHINs meant six months ago. The public doesn't know anything and our own members, 90% of them, don't know what LHINs are. And we're going to have it in law as soon as a month from now. That's crazy.

Ms. Martel: Thank you for making a presentation today. I wanted just to touch on the powers that the minister and/or the LHINs have. Some of these are shared; some of these are exclusive:

"(a) to coordinate services ... between different persons and entities,

"(b) to partner with another person or entity in providing services ...

"(c) to transfer, merge or amalgamate services, operations, persons or entities,

"(d) to start or cease providing services,

"(e) to cease to operate or to dissolve or wind up the operations of a person or entity."

That's under the definition of "integration."

My point is that nobody should have those powers—not the LHINs, not the minister. The sad part of what is happening here is that the government tries to say the LHINs are going to be close to the community; they're going to be able to make decisions on behalf of the community. The fact of the matter is, the LHINs are agents of the government. They are appointed by the government; they serve at the behest of the government; the budget they have comes directly from the government; the accountability agreements that they have are with the minister, not with the community—and the list goes on and on.

My concern is that you've got powers with respect to the minister, for example, that are the most that we've seen in terms of centralization in any other piece of health care legislation, including even what was done under the previous Conservative government. But what you have now is the government establishing a buffer between itself and the community so that with really nasty, unpleasant decisions the minister can say, "Oh, don't blame me. Go blame the LHINs." You can't go blame the LHINs because they're not accountable, they're not elected, they're not appointed by the community. So you've got nowhere to go when nasty decisions are being made. How comfortable and confident do you feel, with that kind of control by the minister to the LHINs, that the local community is going to have any kind of important say in the decisions that are taken?

Mr. O'Brien: The LHINs are saying this is local. This is not local. Some of the LHINs are the size of Nova Scotia and Manitoba—for example, ours is. It's the size of a province and you've got nine people appointed. And they have unbelievable powers. That's totally inappropriate, in a democratic society, to have a board that's appointed. They don't have to go before an electorate, they don't have to go anywhere and they're going to control \$21 billion of the health budget—that's two thirds. It's ludicrous to even think that.

We're asking your committee to decide to scrap this bill and start over. If you want to do this, start over and do it the proper way, by consultation first, then proceed

on to legislation if you want to make those changes. But you can't put the cart before the horse, because this is craziness.

The Chair: Thank you very much for your presentation.

Ms. Clapp: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, THUNDER BAY

The Chair: The next presentation is from the Canadian Mental Health Association, Thunder Bay, Maurice Fortin. Good morning.

Mr. Maurice Fortin: Good morning. I understand I have 15 minutes, so I won't read the presentation to you. But I want to touch on some aspects of it that I think are important.

The Canadian Mental Health Association, Thunder Bay, has existed in this community since 1975. We're a non-profit, registered charity that came into being as a result of a need for aftercare services for folks being discharged from hospital. Today we provide a range of services, including a day program for folks who have serious mental illness and a crisis program for the city and district of Thunder Bay that really serves all of those communities in the sense that it answers the telephone for whomever calls. We anticipate that we'll hear from more folks as we see layoffs across the Thunder Bay district. We are accountable to this community through a board of directors of 15 individuals who represent families, consumer survivors, the business community, and health and social service providers.

My first general message to you is that the mental health and addictions sector gets it. We've been involved in developing integration strategies over the last three or four years. Many of us sit at mental health and addictions planning tables and we are already developing strategies to integrate service. So hopefully as LHINs come forward, they will look at some of the important work that we've done and continue to build on that. Currently, we're developing an early psychosis program as a regional program, and that will serve both districts. It is causing us to partner with any number of service providers, both hospital and community, across 14 communities. We're very excited about that.

1040

I want to speak to some of the important issues within LHINs that we have some concern about. First I want to talk about the integration piece. I want you to know that we support the need for LHINs to hold organizations accountable for the delivery of the integrated service plans. But we are concerned about the section of the legislation which provides power to force non-profit organizations to cease operating. We don't really believe that LHINs should have the power to make an organization that has existed in this community for 30 years go away. There is also a very practical issue around causing organizations to cease operations. We have a number of contractual obligations with other organizations. The

Minister of Health and Long-Term Care is not our only funder. So certainly from a practical point of view, you need to think very seriously about this particular piece of the legislation.

It was interesting this morning that on the CBC news I heard one of your ministers express some concern about potential changes to childcare funding which will cause you to be in some serious breach of your contracts with providers. I think it's ironic today that we are in that position and that you are mandating that position.

We have no problem with the withdrawal of funding for transfer payment agencies that aren't meeting their contractual obligations.

I also want to point out that part V of the legislation, which allows for 30 days to request consideration of a LHIN's integration decision, is simply not enough time. The legislation must allow for due process and fairness, including expanded time frames, to allow organizations to respond to such important decisions.

There's a section of the legislation that addresses the alignment of community care access centres and provides for the future expansion of the mandate of CCACs to assume a broader role in the future. While it's not stated in the legislation, certainly within the provincial, regional and local networks of mental health service providers there is unanimous opposition to the development of a coordinated access to service through a single access point operated by CCACs. We are concerned that in allowing for a broader mandate, you are moving in that direction. The opposition to a single access point stems from two perspectives.

Routinely, individuals with mental health and addictions issues access the system through multiple points. They include crisis centres, detox centres, emergency departments, primary care centres and regular intake processes. Their need for services is often acute and immediate. A system requiring individuals to queue up for assessment and referral will not serve the needs of this population. Mental health and addictions providers should be supported by the LHINs in developing "every door leads to service" strategies to ensure timely access to service.

Our second concern about that approach, specifically a managed competition proposal call process where potentially service will go to the lowest bidder, is that mental health and addiction services require highly skilled interventions by competent and trained professionals. Consumers of mental health and addiction services and their families require long-term, continuous interventions and strategies to support their full return to community life.

I want to say a little bit about the provincial strategic plan, which is also referenced in the legislation. It is no coincidence that the priorities related to mental health and addictions during the LHINs consultation process were virtually the number one priority across the province. In most jurisdictions they either scored 1 or 2. We know that the prevalence rates for health issues related to mental health and addictions continue to rise and are resulting in profound individual and societal impacts and

costs. We want to encourage the Ministry of Health to protect the mental health and addictions envelope within its strategic plan. Historically, such services have been poor cousins to issues such as cancer and heart, and we expect that to continue. Within the LHINs process, there is concern that those better-known, more acceptable health issues, often supported by public sentiment, will become the funding priorities. Will we be competing with organizations such as hospitals and cancer care centres to make our priorities known?

I want to comment as well about the community engagement issue. We support the need for the LHINs to include the facilitation of the involvement of service providers and health system users in planning and in developing the plans for service delivery. However, the degree of involvement of consumers and families of mental health and addiction services is of particular concern. This group has historically been marginalized as a result of social and economic issues such as poverty or the devastating impact of illness. We encourage the Ministry of Health and Long-Term Care to recognize the need to consult consumers and families on mental health and addictions planning and to require their involvement through your stated policy. This has been the case in other jurisdictions such as Australia.

One of the concerns with respect to the LHINs legislation is that it has not referenced or included other determinants of health. Those determinants of health include an adequate income and safe housing. We are concerned that a number of these issues are under the jurisdiction of a number of other ministries: income and disability under the Ministry of Community and Social Services; housing under the Ministry of Municipal Affairs and Housing; children's mental health under the Ministry of Children and Youth Services; health promotion and illness prevention under the Ministry of Health Promotion. How will these important functions that impact on the determinants of health and, ultimately, on your strategy and your vision for health be recognized and connected to the provincial plan and the LHINs planning process?

Of particular concern to our sector is the role of planning for safe and affordable housing, either with or without supports. We would recommend to you that the ministry continue to assume central responsibility for the planning and delivery of supportive housing for mental health and addictions consumers.

Finally, the issue of LHINs and accountability: While the legislation refers to the need for LHINs to engage in community engagement, those terms are not well defined. Given the vast geography of LHINs 14, what mechanism will be in place to ensure participation of communities such as Atikokan, Manitowadge and Red Lake, to name but a few? How will First Nations be engaged in urban centres and on reserve? Most importantly, what will be the mechanisms to ensure that LHINs do not ignore a strong consensus in planning and direction from community stakeholders? The legislation requires that LHINs act in the public interest, but the concept is not well defined. What will be the mechanisms to ensure the

accountability of LHINs to the communities and to the region they serve?

In closing, I want to thank you for the opportunity to speak to you today about this important legislation, and I welcome any questions you may have.

The Chair: There really isn't time left for questions, but we thank you for your presentation.

1050

THUNDER BAY HEALTH COALITION

The Chair: The next presentation is from the Thunder Bay Health Coalition, Charles Campbell, spokesperson. Mr Campbell, you have 15 minutes in total, which you can choose to use or allow us to ask some questions.

Mr. Charles Campbell: Like the previous speaker, I won't read through the entire package; you folks have that. I want to hit on a couple of specific areas of concern.

First, I would like to compliment the government. The principle laid out in the preamble to the LHINs document is very positive. Probably with the exception of the LHINs structure itself, we think that most of the goals and things that are laid out there are very strong and positive messages. Our concern is that Bill 36 is not going to achieve those goals, but is going to achieve a much different end.

We're also concerned that the LHINs' mandate, of course, ignores or excludes practitioners, clinics, public health and a number of other areas. The concept of integrating the health care system, when you've got some of those key delivery agents not part of this exercise, is a significant concern. I know that members of our aboriginal community have spoken, and will be speaking as well, about their concerns. The issue of jurisdiction around the federal and provincial responsibilities is key in those communities.

Geography is one of our big concerns here in the northwest. You're dealing with a part of the province that has 2% of the population, so in terms of provincial priorities, most of us recognize that we don't register very strongly. However, we've got 60% of the land mass. If you pick up the northeast, you're probably picking up about 35% of the rest. If the LHINs model is about low-cost delivery, we're cooked. We can't deliver over that land mass the kind of efficiencies you're going to get in an urban area. I'll quote somebody who would probably be quite happy to see a LHINs-type model introduced, and that is Michael Decter. His comment from his book, *Four Strong Winds*, in 2000 was:

"The early evidence from two of the first Canadian provinces to adopt this model"—that is, regionalization—"Alberta and Saskatchewan, is that the system works well in urban areas.... However, the regionalization of rural health services, which have been accompanied by the closure of many small hospitals, is less clearly a success."

The reality is that if you look at Alberta, Saskatchewan and BC in Canada's situation, rural areas continue

to be hammered by these sorts of services. It's fine to be able to have a shorter wait list, but the reality is, if that shorter wait list means you're now spending three weeks in a hospital in an urban area 1,000 or 500 miles away from home, incurring a lot of those operational and travel costs yourself, the health care system just saved some money, but you haven't had any real benefit to yourself as far as your costs are concerned. You've just transferred those costs, and that's a concern.

Under the current system we're operating under, we've got Dr. John Porter, who's going to be doing joint replacement outside of Thunder Bay. In a LHINs model, I'm not sure that would be a cost-effective way of doing it. If we find a hospital in Ottawa that can do joint replacements, I am concerned that we then leave ourselves open to saying, "The model says economy and efficiency. Let's start shipping people to where we can do the cheapest surgery." I won't revisit the issue of the travel subsidy and the partial costs and the other issues there, but clearly if you're going to start shipping people and you're not bearing the cost of that, you're not properly reflecting the reality of the geography we deal with.

The second issue I want to touch on briefly—I'll try to be brief—is accountability. The government is restructuring health care again with the LHINs. There are a lot of things, as I said, in the preamble that sound really positive about where we want to go. But when I read through the document itself, the LHINs are being given significant powers to reorganize and restructure health care in the region. Although there are words about accountability in the preamble, when you read through the details, they're also given very clear mandates that refer to accountability to the minister and to the Ministry of Health, not to the communities.

There's consultation with the communities and providing the communities with an opportunity to say things, but the reality is that when you read through section 5, with the specific language around accountability, clause (b) makes "recommendations to the minister," clause (e) is "be accountable to the minister," clause (k) is "in accordance with provincial priorities," clause (m) is "to account to the minister," and clause (n) is "that the minister specifies." Those are all references to the minister's responsibility.

Nowhere in the material did I find references to being accountable to the community. There is no formal structure to provide accountability to the community, other than through the ministry. I'm not sure how making you accountable to the minister is supposed to provide a warmer, fuzzier feeling from us out here that there is accountability to the local community, because the ministry is accountable to the minister. How have you changed anything if the lines of accountability go back to the ministry anyway?

There are some other things, as I said, in the package that I won't go into in detail here. We are concerned, however, about the fact that one of the bill's mandates is to have the LHINs established, staffed, put together, and then go out and try to plan out what it's going to look like

to deal with conflict of interest guidelines. It seems to our organization that if you're going to establish a body with these kind of powers and you're going to staff it through central appointments, you should have had an accountability framework that was starting from—as opposed to having people put in a position where they're given a series of responsibilities and then, after that fact, they're given responsibility for creating their own conflict guidelines.

The third concern we have is very much around the free market model. We can say what we want about all the warm and fuzzy words that are referenced in the package around the need for Canada Health Act enforcement, but the reality is that what we're talking about is introducing a system which, as its primary criterion, evaluates the medical system, the health care system costs in a market fashion: in effect, set pricing, try to find the lowest price for services, throw all the services into a bag, bid them out, put price stickers on all of these services.

We don't have a problem with trying to assess and properly value the health care system we have. However, if you want to set up a sticker price system for health care services—the practices are being followed in other jurisdictions in Canada, in Europe, in New Zealand and in the US—you establish a pricing system. You then, in effect, are introducing an opportunity for private business to come in and say, “Okay, now we know what we're bidding against.”

No disrespect to the process of tender, but the reality is that once you've got the contract, when the bills start to come in, are you going to hire from a private service agency and start to say, “You know what? Maybe you'll just have to put those patients out on the street because your prices are too high”? No. The reality is, once you've introduced that tendering system, once you've brought in a pricing system that allows people to establish, “Here's what we have to target for our pricing,” you will see more privatization of the system.

We've seen that with the boutique clinics in Alberta and other jurisdictions. This will lead to that, if that's the process we're going to take, because the LHINs legislation does not fundamentally show anything in that material, that we could find, that is establishing community value. It talks about accountability, it talks about efficiency, it talks about finding the most effective price for delivering a service, but it doesn't talk about what happens if the doctors who are in Terrace Bay are told, “Your pricing is a little high. We can get the same service somewhere else. We'll transfer you to Toronto.” It doesn't talk about the community impact of those communities. It doesn't talk about the fact that downsizing in places like Atikokan in the medical system has meant that people have to come to Thunder Bay if they're looking at doing a delivery or any kind of practice, and those costs are not something the LHINs have to deal with. So those are significant concerns we have.

In conclusion, we believe in a strong public health care system. We believe the accountability framework that is discussed in the preamble to this bill is good—that

is, establishing local input, allowing local contributions to the process—but we are concerned that the bill, in its actual execution, is deeply flawed.

The Chair: Thank you. Thirty seconds each.

Mr. Miller: Thank you very much, Mr. Campbell, for your presentation. You talked at length about accountability and how the LHINs will make the system accountable to the minister, but not the communities. What do you think will happen with hospital boards after this LHINs legislation passes?

Mr. Campbell: I'm not sure the hospital boards will have a fundamental change in how they operate. However, my concern is around the integration issue. The hospital boards may well survive, and the issue of accountability there may also be an interesting one in terms of providing more open-meeting details and more openness toward how hospital boards are operating. That would have been good to see.

I'm more concerned about things like a lot of the social service agencies; for instance, the one that was here just before me, talking about their local community boards and how their relationship with the health care system could be changed if the LHINs, given the powers they have, say, “Health care services are more effectively done by one agency. We're going to merge five of you, and now we're going to tell you where your assets are going to be transferred,” because the legislation does allow for that to happen.

Ms. Martel: Thank you very much for your presentation today. I want to focus on the market tendering system, or competitive bidding or cutthroat bidding. You just have to look at the CCAC model to understand that there has been huge privatization of home care under the cutthroat bidding model. The U of T did a study in 2001, and even though it had only been in place for about four years at that point, there had been a shift from 18% of those in the marketplace, or for-profit, to 48% by 2001, and I suspect we're well over 50% by now.

The minister, on the first day of the hearings, said, “There's nothing in this bill that says we're going to have competitive bidding. People who purport to say that are providing misinformation.” My point is there's nothing in the bill that says it's not going to happen, either, so if it's not going to, then put it into the legislation. Given what's happened in home care already, what are your concerns if that model is applied to all of the other health care services that LHINs will have some responsibility for?

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Mr. Campbell: Similar to your comments, whatever is said in the bill, clearly there is nothing said about not using competitive bidding. The other thing is that although competitive bidding is not explicitly referenced, the wording of the bill around the accountability issues, when you look at other jurisdictions in Canada where these sorts of regionalizations have happened, unless the government is planning on trying a brand new model for regionalization, the competitive bidding process seems to be the way that accountability and efficiency—those words are used heavily in the document—are introduced.

If the government is looking at introducing something that looks differently from the other regions, it would have really been appropriate, I think, for the government to go through the process of that consultation and the minister's strategic plan consultation prior to erasing the existing bodies and establishing new ones. I'm not sure exactly what the LHINs are supposed to implement in the next 12 months, unless there's a document on a shelf somewhere that most of the public has not seen that tells us what health care is going to look like.

Mr. Gravelle: Charles, as always, thank you for your very thoughtful presentation. I know you put a lot of work into that.

In terms of accountability, that's a huge issue, and even in terms of representation. I spoke earlier when Jules Tupker was up here as well. There's an assumption that there will be fewer services as a result of this. It's the assumption that's being presented.

I work from a different premise. We're going to have representatives from many communities throughout the northwest. We know the northwest LHIN is a huge one. It is going to be really challenging, but the fact is that we've got representatives from communities who understand better than anybody else the need that they maintain services, and we have recommendations from Mr. Closson's report which suggest more services in the communities, more service to be provided out of Thunder Bay to take off some of the stress that's presently on Thunder Bay Regional Hospital, for example.

My question, if there is one, is—I mean this as politely as possible—why do you assume it will be going in the other direction when I think we're going to have people who are going to be able to very clearly, on a regional basis, make the point very strongly that we should be having an expectation that whether you live in Dryden, Kenora, Marathon, Greenstone, there are enhanced services? Again, recommendations are out there to quite literally enhance those services by putting in the district hospital designation that Mr. Closson has recommended.

I would not be supporting a reduction in services myself, as the member representing a large part of the northwest LHIN, but your thoughts on what I'm saying?

Mr. Campbell: The reality is that we definitely need more services. We recognize that. We certainly have heard a lot of good things in terms of verbiage about the services we need from various groups in the health care system. My concern is, and I'll go back to what I said a few seconds ago, where is the strategic document that's supposed to lay that out?

Why have we removed one group that was being selected from within communities prior to this LHINs model? We had a number of regional health care agencies in place. We've wiped those organizations out, replaced elements of them with the LHINs, so we haven't changed, I don't think, community accountability other than we've got fewer LHINs than when we used to have the old health agencies. We've reduced the number of bodies that are representative. We've reduced the number of members. There's a maximum cap of nine on each LHIN's board.

The community representation: I don't want to take anything away from the people on those boards. A number of us on the local health council thought it might be appropriate to apply for those boards as well, but our concern is that those boards are clearly accountable to the minister. The minister has not chosen to show his hand in terms of what that strategic plan looks like, and those boards are very much directly accountable to cabinet and the minister for their existence, similar to the situation we've seen in other boards, certainly in the way the province dealt with hospitals and the boards of ed under the Conservatives. When you've got a board that is directly accountable to the minister and cabinet, it really makes it a little bit harder for you to voice concerns than would otherwise be the case if you were accountable to members in the community.

Michael, I hope you're right, that what we're going to see is an increase in services. However, the verbiage and the language around the responsibility of the LHINs is very clearly around the structuring and restructuring of the system. I don't see a lot of verbiage around strengthening communities. I see a lot of verbiage around how the system has to be rationalized. My concern from other jurisdictions is that unless we see something other than that sort of verbiage in the operational lines of the LHINs, I have a hard time trusting any government until I see some track record that says we've got a stronger commitment in the legislation, not just in the verbiage press releases that come out after it.

The Chair: Thank you for your presentation.

KENORA RAINY RIVER DISTRICT ADDICTION AND MENTAL HEALTH NETWORK

The Chair: We'll move to the next presentation, from the Kenora Rainy River mental health and addiction directorate's network.

We have another name, so maybe you want to introduce yourself. Welcome.

Mr. Jon Thompson: Yes, Diane wouldn't be too impressed. I'm not trying to pretend I look like her. She's much more attractive. But we do agree on many other things. My name is Jon Thompson and I'm one of the other managers that is part of the northwest network.

The Chair: Please start any time you're ready, sir.

Mr. Thompson: Thank you very much. I apologize, too. We had a technological malfunction this morning, so you don't have our five recommendations. But we'll get through them now and we'll give them to you afterwards, perhaps.

First of all, just as an overview, the Kenora Rainy River Addiction and Mental Health Network—just briefly, as to know our context and who we are—basically represents the 16 funded addictions, mental health and consumer provider organizations in the Kenora-Rainy River district, basically north and west of here. Some of those are sponsored, some of them are free-standing, some of them also provide violence and sexual assault services as well. For 25 years, we have been advocating,

planning, coordinating and trying to improve access to care for the folks that we provide service to, providing both efficient and effective services at a local and district level. I think we've tried to encompass the spirit of much of what the proposed legislation is intended to do in the new LHIN environment, in the sense of being open, flexible, visionary and progressive in our thinking, as we work with each other across the vast distances in our districts.

We'd like to start too by saying that we certainly echo much of what you have heard already, or will hear, in your series of hearings around the province, particularly the things being said by the Canadian Mental Health Association, the Centre for Addiction and Mental Health and the federation of Ontario mental health and addictions programs. We share a lot of similar interests, sentiments and whatnot, but today we'd like to take a bit of time to talk about and highlight our particular perspective on some things in the Kenora-Rainy River district.

Overall, we certainly do endorse the main principles underlying this particular legislation. We are way overdue for reform. We welcome it, almost reaching out for it; we really desperately want it. But there are a number of concerns with this particular legislation that we share with others.

Our first recommendation is around the recognition of how broad the prevalence of mental health and addictions problems is in our area. Directly, right now, we are probably providing, or are accessible to provide, service to almost 22,000 folks in the part of the catchment area that we serve outside of the district of Thunder Bay. With that kind of impact—I think the socio-economic costs of addiction and mental illness are well established. The importance of making this sort of silo mainstream is the opportunity now, and if we could bring that in in an appropriate way, we think that would be a major home run for health care in general and certainly to make this sector feel a full and important part of it. So our first recommendation along those lines is to ensure that the regulated and non-regulated mental health and addiction services are recognized as primary care services and included as core components of the northwestern Ontario health care system to ensure a holistic, consumer- and family-focused and coordinated approach to care.

Our second recommendation is related to funding. At another hearing last week, we talked in more detail about our perspective on that, but this particular legislation doesn't seem to address the funding mechanism issues very well, as far as we can see. The funding for our sector in particular is, frankly, just a big mess. It ranges from the inflexibility of the silos to the inadequacy of funding in some cases, to the lack of provision to move things around to do things in more effective and efficient ways. So, along those lines as well, our second recommendation is that this legislation needs to develop or commit to a funding mechanism that is sustainable over a period of time, recognizes the need for both re-allocation and increased resources, recognizes the cost of accountability and compliance—and by the way, we have so

many of those things. I, myself, do 29 reports 73 times a year, and I didn't go into this business to do that.

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Also, as others will say, I think our sector has a sense that our resources need to be at least protected for a while—the notion of ring-fencing or a protected envelope—to ensure that they don't filter off, or, as we compete with some of the bigger players and whatnot, we don't just get lost in the shuffle.

The third recommendation is related to the principle that I think this legislation is headed towards, which is to ensure that there's no wrong door for service and that all doors are open. So from a consumer point of view, wherever they reach into the system they are going to get the appropriate range and scope of services that they need. To do that, our services have to be fully recognized, as I said earlier, as core services so that people identify the need for them, no matter where they are, and can access them. So there needs to be responsiveness, accessibility and that type of continuity of care.

That led us to another thing: We're somewhat puzzled because we want to be more inclusive, and we're wondering why this legislation is leaving out some other significantly big providers of health care. That led us to recommendation number 3, which is recognizing that service providers in our sector are, first of all, health care providers and that also physician, pharmacy and public health services should be somehow included in the scope of the LHIN. We realize these latter three groups are currently excluded, but we really can't see how we're going to make much progress on the integration, the breaking down of silos, if these things don't come together very much.

Our fourth recommendation is related to the issue of engaging the community: providers, consumers and that type of thing. It's not clear, again, from this legislation how that's being defined. For example, "local" in this case might be the whole of the northwest LHIN, which you've heard is a very large area. I think we'd like you to consider the concept at least west of here. Most of the services are organized along both economic and social lines, along the catchment area concept. There's a hub in the small community. There needs to be a range of direct services and supports there, and so on and so forth. We certainly don't want to lose that. We think that's a winner right now, and we certainly want to be able to preserve that. So we can't see how a lot of direct services can be delivered on a regional basis, and we're wondering how that's going to happen.

We're hoping that the legislation in this case, recommendation number 4, legitimizes and recognizes the role of progressive consumer and provider networks such as ours by delegating and resourcing specific planning tasks to be accomplished. I know this is going to be a very challenging matter, but I think there's some good work that's been done already that we could certainly build on here in the northwest. But we have to have the authority to do some things, some clear mandates to do some things, and the cost of us getting together to do these

things has to be recognized. Right now, I think our network northwest of here feels like we're doing a major planning function for addictions and mental health. It's not really recognized by anybody, and yet we seem to be asked to do a number of things.

Our last recommendation is around the notion of integration and what it means. "Integration" seems to mean everything from, "Let's talk together a little bit more," to, "Let's all get together in one family type of organization." We have a fear that too much of this legislation is focused on that end of integration, meaning that there should be less transfer payment agencies, particularly in our sector. We know there are quite a few, but one of the things we have to emphasize is that there's such a richness in our tradition over maybe 20 or 30 years—our history, culture, diversity of approaches to health care, the philosophies of care that we use—that we feel it would really be lost in larger organizational structures. In any case, even if you pull us all together, there's not a lot of money to be saved. We don't make up much more than 4% of the total health care budget. So even at our worst, floundering about, we're not costing anybody a whole significantly relative lot of money on that level.

The other thing too is, a lot of folks are fearful of section 28—or the "hammer," as I guess some people might like to think of it—a provision that the minister or the Lieutenant Governor in Council would have to force mergers and whatnot. Our sector really doesn't need that. I think we've recognized the ability and the need to change and have done so on many occasions, probably more along the lines of coordinating services, redistributing resources, partnerships and that sort of thing, rather than all being part of the same organization. I think we've had some success with that.

Our last recommendation is related to this. We would certainly recommend that there must be more due process or procedural fairness in regard to some of these integration decisions. We also think the decisions should reflect some other dimensions, such as ensuring there's a comprehensive range and minimal service availability, particularly in some of our small and local areas, the accessibility question and also supporting services where there's been good focus on the quality of care.

Thank you for your time today. I'd certainly welcome any questions.

The Chair: Thank you. We are right on the nose, but we'll allow 30 seconds each, if I may. I will ask Madam Martel to start with 30 seconds only, please.

Ms. Martel: Thank you very much, Jon. I'm not sure how far you had to travel to be here today from Kenora-Rainy River, exactly what community, but thank you for making the trip.

In my part of the world, the community mental health and addiction organizations have long operated as a cohesive unit. There is no duplication. Just because of the funding they've received and the lack of professionals, they've had to work together for a long, long time, so we don't see that kind of duplication. What we do see is a need for additional funding to provide additional services. There are no savings to be had by cutting any

groups out any more. If anything is required, it's to get some actual funding to provide new services. I don't know if you can speak to that from your perspective in this part of the world.

Mr. Thompson: Yes, we've done some work on that. We don't want to sound like we are—because everybody sounds like they're whining for more money, but at least the ministry needs to recognize their own benchmarks for funding. They've set some minimal levels in our service for 15 years—and I think it's been the responsibility of the last three governments of all parties—and the bureaucracy just hasn't got the job done that we sense is mostly their job to do, which is to make sure our services are sustainable. We are still at levels of funding—we've had 2% or 3% increases over 15 years. That's not fair or equitable or going to get you good quality. That gets you people leaving, trying to do other things and so on.

We estimate that the gap right now in the Kenora-Rainy River district—just using those simplistic kinds of notions—between where we are now and where we should be is about \$9 million. We got \$1 million last year, which we very much appreciate, but it took a great deal of creativity to get it into the right kinds of silos so that we could provide the kinds of services and make sure it was meeting the basic gap needs that we felt we had.

Mr. Mauro: Jon, thank you very much for your presentation. You used one of the words in your presentation—"silos"—that people talk about all the time, that it is why the health care system in fact is not a system, that there are so many inefficiencies created and resources wasted as a result of the inability of the different sections of the health care section to actually work together as a system. One of the things that the LHIN is hopefully going to be able to do, if in fact it moves forward, would be to have local, resource allocation decision-making authority, so that communities and sectors of the system like yours would be in a position on a local basis to ask for and potentially receive more resources.

Quite frankly, you learn in this job that, historically, hospitals are viewed as a big drain on the health care budget by other sector providers like yourself. People will come into my office and say that historically, the hospitals have always had their budgets funded when they've overspent and that it's to the disadvantage of other groups like mental health service providers. So I was very interested in your comment. It seems to me you see the potential for something positive here as it affects mental health because a LHIN would have resource allocation decision-making authority once the finances flow in 2007. I wonder if you could comment on that a little bit more.

Mr. Thompson: Sure. Yes, we would agree with that, but I think what we're saying—and I actually should have emphasized this too. Our group and some of my colleagues have been quite involved with the planning initiative of the LHINs that led to this legislation. The number one administrative priority, as I hope you know,

in this district, was let's get the money right, because it's so fundamental, before we get into this thing. I think we've got to do some transitional things. We've got to up-resource some of these sectors to balance this off before we all hit the ground running after the establishment of the LHIN. Our fear is that the assumption will be that the status quo is all right or it is what it is, and we don't see how we're going to do much differently, and we're probably going to be more at risk if we go into the LHIN environment with that. So we want to go in and we want to be part of it and break down those silos—very much so—but we have to have an ability to be there. If we're not there, if we're cutting back and reducing services, there will be less and less of us to be at the table to even have this discussion with or, more importantly, for the consumers to get the service from.

I guess it's important to have more emphasis on looking at models. We've got ideas, others have ideas—good, bad, ugly, whatever they are. But we've got to find some other ways to finance this too. We've got to look at other ways to bring the resources into the system, not just pound the table and say the same old same old. That's why we're saying there are reallocations that could be done and there's also so-called new money that we need to find.

Mr. Miller: Thank you, Jon, for your presentation. The Canadian Mental Health Association presented earlier. I noted in your presentation that you said funding is a mess. The Canadian Mental Health Association said they are concerned that, through the LHIN planning process, mental health might be sort of pushed aside. What they said exactly was that within the LHIN planning process “there is concern that those better known, more acceptable health issues, often supported by public sentiment, will become the funding priorities.” Are you worried that, through this model, mental health will receive less funding?

Mr. Thompson: Yes, we're worried, but I guess that's why our first recommendation was about getting the public engaged, as they are by receiving our services already, but recognizing that their more traditional medical issues like heart attacks, strokes and cancer all have psychosocial, mental health and, actually, addictions and violence aspects, if you really want to drill down into these issues, as we've learned. We're trying to avoid that debate, actually, so we don't want somebody to say: “Look, you can have a mental health counsellor or you can have a heart surgeon. What would you rather have?” We're saying we'd rather have both in the appropriate amounts and where they need to be. That doesn't mean we have to have in each of our smaller communities a range of tertiary heart surgery specialists, but I think we're saying that we need a range of community counselling, mental health kinds of services that are very much direct service and right at that front line.

The Chair: Thank you very much for your presentation.

The next presentation has cancelled. We will have a five-minute break. We should be back just before 11:30.

The committee recessed from 1125 to 1142.

WESWAY

The Chair: We will resume for our next presentation: from Wesway, Carol Neff, community services facilitator.

Mr. Gravelle: I'm escorting her, Chair.

The Chair: Oh, thank you, Michael.

Madam, you can start any time. There are 15 minutes for you to make a presentation.

Ms. Carol Neff: Okay. Thank you very much, and thanks for the opportunity. My name is Carol Neff, and I'm from an organization called Wesway.

Wesway has proven its leadership in the field of respite care services for the past 32 years and offers a full range of respite care services for family caregivers, including in-home and out-of-home service models, delivered by volunteers and by staff. Flexibility and creativity are the hallmarks of our success in meeting—

The Chair: Madam, I'm sorry. I'm told that there are some technical challenges. Can you start all over again? We were not able to record what you were saying properly. So we have to start over. Just one second.

Madam, you can start now, please.

Ms. Neff: Okay. Great. I wanted to speak about respite care a little bit before we get into our specific recommendations, because that's the service we provide, and we're very much involved in the life of the community. We believe that family caregivers are the real bedrock of the community care system, and we have to provide them with the breaks they need to renew their energy. The responsibilities of providing 24-hour, ongoing care can be very stressful on families, and the timely provision of sufficient levels of respite care can sustain the strength of a family, while preventing potential crises, family breakdown and much more costly alternative interventions.

We see respite care as something that benefits absolutely everyone: the individual, the family and the community, and the service system as a whole. Respite care is so cost-efficient that it makes sense to invest more in this area, even when dollars are scarce. Personalized respite care services result in stronger families, the preservation of dignity and respect for people with special needs, and clear cost savings for the service system.

I want to say that Wesway actually has a very proud history of success through collaboration, integration and creative partnerships. That's at the core of this new legislation. We've also been blessed in that we have a multiplicity of different government funding streams, and we serve many different target populations and have lots of community connections, which has helped to generate some unique opportunities for maximizing our resources. I wanted to give a couple of examples of how that has worked for us.

For example, we have one of our respite home locations where we serve both children with high and multiple needs, as well as seniors with Alzheimer disease or a related dementia. The capital development and operating expenses for this site have been co-funded by two different ministries, together with contributions from

charitable foundations. So without the collaborative funding arrangements, the vital respite services that we offer there just wouldn't exist.

We have other examples where we've maximized the effective use of space by partnering with other organizations to make the most of the sites that are available.

In terms of our expectations in terms of working with the LHINs, we believe that the LHINs are founded on the principle that local people are best able to determine local health care priorities. The aim is to create an environment where local health care providers come together and coordinate their service delivery through integration and collaboration. Wesway certainly supports the provincial government's vision of improving health care delivery by focusing on individuals and their families and becoming more responsive to local health care needs.

With our aging society, the need for sustainable and effective community support services is greater than ever. Most people wish to have services available at home so they can continue to live in the community as long as possible. That's what Wesway strives for every day. So we're actually very excited by the prospect of new partnerships and opportunities emerging with the new health care system, and we're fully committed to working with the government and our community partners in the new LHIN structure.

There are some critical themes that we wanted to identify that relate to the LHIN structure, but also specifically in the area of community support services and, even more specifically, around respite care services. I don't believe we've begun to see the impact that respite care services could actually have in terms of alleviating some of the pressures on the health care system. There's a huge potential, and we could play an enormous role.

A flexible range of respite care services will help to generate huge savings, compared to the more expensive alternatives such as hospital admissions and long-term care homes. The onus for care has clearly shifted to family. Up to 90% of the care of elderly people is provided by family caregivers, and the health system would collapse if they didn't make that sacrifice. Perhaps the most severe alterations to caregivers' lives are the changes in their own health status. They report high stress levels, fatigue, negative emotions, depression, psychological distress, interpersonal conflict, loss of sleep and social isolation. Caregivers often put their own health in extreme peril, resulting in additional hospital admissions. By 2020, seniors are going to comprise 20% of our population—in other words, one in five people will be a senior—and the current system providing community care remains fragile, inadequate and not ready to meet the aging challenge.

Institutional care is estimated to be 10 times more expensive than providing care at home in the community, yet the emphasis on institutionalization persists. In fact, only 1% of the total health care budget is allocated to community support service agencies.

Families seeking respite care may be placed on a lengthy waiting list, where they may wait many months,

even years, and all too often their family members die or are placed in long-term-care homes before receiving respite care. So trying to manage without the respite they need may be possible for a time, but sooner or later the health and well-being of caregivers is compromised. Crisis develops, and much more costly and intrusive measures may be required along the lines of hospital admissions or long-term-care home admissions.

The demand for respite care is growing rapidly, and for the caregiving families the need for respite is urgent, and the timing is actually very critical. Appropriate respite care is preventive in nature and a very cost-effective investment for long-term community support. So when we respond to Bill 36, Wesway supports the underlying principles—certainly the changing culture, expectations and behaviours to achieve a vision of health care that is client-focused, results-driven, integrated and sustainable.

Local health needs and priorities are best understood by the local community. Active community engagement is a critical component to facilitate responsible decisions. A better coordinated health care service delivery is essential to support people to navigate across the continuum of care more easily.

Choice is an essential component of our health care system, and individuals and their families need to be engaged. Equitable access based on individual need is required as close to home as possible. Measurable, results-driven outcomes based on strategic policy formulation, effective planning and information management will certainly aid in accountability. People-centred, community-focused care that responds to local population health needs is at the core of an improved system, and shared accountability involves providers, government, community and citizens.

Wesway sees that there are a number of overarching requirements. First of all, the LHIN legislation must embrace the fundamental values contained in the Canada Health Act—specifically universality, accessibility, portability, public administration and comprehensiveness in the broadest definition of health care—and also of the Commitment to the Future of Medicare Act, including open accountability, transparency and public administration.

LHINs must work to ensure the acute care sector focuses on acute care clients only. Specifically, we need strong community-based respite care services for people with disabilities, the frail elderly population and people with Alzheimer disease and related dementias to assist family caregivers in the community. A more vigorous concentration of resources in this area will help to avoid visits to the ER or hospital admissions and keep space open for people with acute care needs.

There's a need for consistent criteria as to what "community engagement" means. Wesway looks for a broad-based, inclusive consultation process with a strong voice for local community-based service providers in the development of the integrated health service plans and health services integration initiatives.

All health care provider organizations have a responsibility and obligations to coordinate care for people as

they move through the system in their health care journey. Every person has a unique set of needs, a different point of access, and a different path of processes and relationships to transition through. System navigation is not a job description in itself; it's a function of every service provider.

Family health teams must be implemented in a way that involves community support services and community mental health and addictions programs as true care partners. Support for effective information technology is critical in the community sector, and system planning is necessary to ensure human capacity and skills to deliver care where and when it's needed.

There needs to be a shared responsibility across the system and at the local level to ensure meaningful HR planning. A critical consideration in a sector of scarce human resources is the impact of integrating services between organizations with wage disparities. The legislation needs to recognize and encourage volunteerism, which is an added value in the community sector.

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Wesway would like to emphasize the following summary points. First of all, with reference to the local health advisory committees that are indicated in the legislation:

To achieve the goals of innovative, collaborative system change, the advisory committees must have inclusive, broad-based representation from all the partners in the health system to provide advice to LHIN boards.

Wesway recommends local health advisory committees should not be limited to the regulated professions alone, which the legislation currently states.

The staff and volunteers of community support services are at the front line of health care service delivery, alongside regulated professionals. Wesway recommends the community support sector should have equal representation on these advisory committees.

With regard to effective and efficient services, Wesway recommends the definitions of "efficient" and "effective" should be defined in the legislation according to criteria that recognize the value of innovation, flexibility and choice. These are at the core of community-based services and they respond to the unique needs of individuals and their family caregivers. They also need to recognize the value of client satisfaction and community responsiveness, and quality, value-added outcomes that respect the "local knows best" principle. Personalized services that truly meet the needs of individuals and family caregivers will produce more positive and cost-efficient results.

Finally, the point in the legislation that deals with the discretion of the minister to force integration: The legislation specifically does propose that option. Local health care services must continue to preserve local community connections, community-based governance, consumer choice and avoidance of service disruption to individuals and family caregivers.

Wesway recommends establishing a requirement for LHINs to incorporate an analysis of the impact of any

integration plan on the people served, the service providers and the community.

The Chair: Thank you very much for your presentation. You have used all the 15 minutes, so there's no time for questions. We thank you for your presentation.

Ms. Neff: Thank you very much.

ONTARIO NATIVE WOMEN'S ASSOCIATION

The Chair: The last presentation before the break is the Ontario Native Women's Association, Josephine Mandamin. You can start making your presentation any time you're ready. Good morning.

Ms. Josephine Mandamin: Good morning, ladies and gentlemen. I am Josephine Mandamin, the executive director of the Ontario Native Women's Association. The Ontario Native Women's Association represents 83 women's local groups across Ontario and was established to promote the betterment and equality of native women. The Ontario Native Women's Association is a provincial organization founded in 1972 which represents aboriginal women and their families on matters that affect the political, social, education, economic and justice issues in their daily lives.

The association has 83 local volunteer organizations, both on and off reserves. These local organizations are divided into four regions across Ontario: north, south, east and west. The locals are autonomous groups and may address any and all issues that affect them. It is based on the belief of unity of all native women. Affiliated with the national Native Women's Association of Canada—NWAC—ONWA represents native women in the province of Ontario, regardless of status or locality. The provincial body encourages the involvement of native women at the socioeconomic, recreational, cultural and political levels.

Aims and objectives: The major tenet on which the organization is based is the concept of unity of all aboriginal women, regardless of legal categories. The main concern of the association is the preservation and promotion of aboriginal culture, language and heritage.

In order to achieve this objective, the association has pledged:

- to create a forum through which native women can become involved in the solution of their problems and the promotion of their interests;

- to help native women increase their feelings of adequacy and their sense of responsibility through planning, developing and managing self-help projects;

- to provide a means through which women can make a contribution of ideas and skills to the social, cultural, economic and political development of Canadian Indian society;

- to provide a means through which native women can assist in identifying those ways which are unique to the Indian culture and through which their role in teaching these ideas to their children can be strengthened;

- to encourage native women to assume a positive and active part in developing skills to support their people in the achievement of their rightful place in society;

- to provide a communications link between native women through which they can relate to each other adequately in fulfilling their roles; and

- to provide a means through which native women can rediscover and develop those traditional skills which have been unique to native culture.

The ONWA cannot emphasize enough the potential hardships the local health integration network process will have on our membership. Without a clear understanding of the governance of the LHIN or its future, we can visualize an enormous breakdown in services and funding allocations to our First Nations organizations and members. Ontario is moving ahead of the national blueprint process without regard or respect for the principles and outcomes that will frame First Nations participation in health systems planning, delivery etc. At the least, Ontario should await the outcomes before introducing their legislation.

Without knowing how the LHINs came about and when they were drawn out, we can only imagine how regional boards will be making all decisions in services and the potential for provincial aboriginal funding to be blended into the mainstream funding, such as diabetes, cancer care treatment, health access centres, HIV/AIDS clinics and many others that I fail to mention here. Funding decisions and priority shifts which are pending will be made by the local LHIN authorities and may reduce the access and scope of health service delivery to our communities and our people.

Without a specific First Nations LHIN board, there is no opportunity to participate in the planning and recovery of health services for our people. Although a seat may be made available on each of the 14 LHINs' framework, we do not see the potential of a strong voice of our people in this promise. The 14 LHINs were implemented and created without consultations with the people of Ontario. Although there were workshops across Ontario in November and December 2004, First Nations were not sufficiently notified of this development, and we watch as the train goes by. The LHIN boards are already established and were in place before we had the opportunity to even consider the affects and effects on First Nations, thereby being unable to provide adequate consultations.

The already established LHIN boards and the LHIN legislation will have significant impacts on the people of Ontario and First Nations health services. We identified areas of concern that our membership has raised.

Language: Our members are entitled to their inherent right to their language, and it must be made available in serving the aboriginal populations in their own language—the Ojibway, Cree, Inuit, and Oji-Cree—as much as the French do.

Transportation: Our members live in outlying communities where travel is a hardship year-round for members on low income; we are all on low income. Airfares are costly. How will the LHINs address these high costs?

Will they provide adequate travel to isolated communities, or will they off-load on the federal government?

Legislation of LHINs: If it goes ahead, we require a placeholder that respects our aboriginal concerns, that the legislation will not interfere with our health rights and services, and to be consulted in a fair and reasonable manner.

The legislation mandates the LHINs to search for opportunities to transfer or merge services, to coordinate interactions and create partnerships between non- and for-profit organizations and move to third parties. What impact will this have on services that cannot afford to compete with big businesses?

Provisions for input and community controls are weak or do not exist. There are no provisions for community appeal, few requirements for public notice, and no protection for equality-seeking groups such as the Ontario Native Women's Association.

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The legislation facilitates privatization in that new powers are given to cabinet for wholesale privatization of non-clinical services. There appears to be a strategy for competitiveness in providing key acute care services in hospitals and contracting out their services to for-profit groups.

The terms "restructuring" and "integration" have many meanings to our membership, from creating a new structure from ones that work and cutting and granting health service providers to contracts for private services. The legislation also gives cabinet the power to establish, dissolve or amalgamate LHINs at will; see part II.

Clearly, more time should be given for the public to have adequate input and understanding of how the LHINs' makeup will affect all Ontarians, whether they are aboriginal or non-aboriginal.

We, the Ontario Native Women's Association, sincerely hope that this legislation does not have any favourable response in the Legislature.

Participation on the LHIN board by the ONWA members would enable the women more input into the process.

The Chair: We have at least a minute each. We'll start with Ms. Wynne, please. We will allow everyone to ask questions or make statements for about a minute.

Ms. Wynne: Thank you very much for being here, Ms. Mandamin. There have been a number of meetings. I want to address the issue specifically around the aboriginal dialogue with the minister, which began in February 2005. There have been at least four meetings with First Nation groups about the LHINs. There was a meeting with the ministry in April 2005, there was a task force created and there's been a report written that is being reviewed with an eye to making some changes to the legislation that would deal with some of the issues that aboriginal First Nations have brought forward to us. Was the women's group part of those discussions? Were you part of that task force?

Ms. Mandamin: It is very well to say that the First Nations task force has been consulted, but they have not

been listened to. Their recommendations still have not been responded to.

Yes, I was part of the First Nations task force group.

Ms. Wynne: That's fine. That's what I wanted to know. I know that the response hasn't been finalized. We're expecting that response within the next few days so that there can be changes to the legislation.

Mr. Miller: Thank you for your presentation today. You brought up the point of the LHIN boards. My question is, what First Nations representation is there on the 14 LHIN boards around the province? Is there representation on the boards that have been set up so far?

Ms. Mandamin: That is our lack of understanding of the LHIN boards. There is no communication with the Ontario Native Women's Association, which is all-Ontario. We have the voices of the women in Ontario, but we have not heard from the Ministry of Health and Long-Term Care who these people are. The only way we find information is through the back door.

Mr. Miller: So you're not sure if there's any First Nations representation on the boards?

Ms. Mandamin: I'm not sure. I know that Alvin Fiddler is on one of the LHIN boards, but I still would like to know who the aboriginal participants are.

The Chair: Thank you. Ms. Martel, please.

Ms. Martel: It is true that we haven't seen the ministry's response to the task force report. It begs the question, given that we don't know what the outcome is. We have a piece of legislation before us, however, that may well have an impact on aboriginal people. If the government was interested in a separate process and in listening to the concerns of First Nations and having a full and comprehensive consultation, negotiation and then implementation, especially on the line of the blueprint, it would have made sense for the government to have, for example, a non-derogation clause in the bill or a clause that would exempt First Nations from the bill until such time as we could see what the government's plan was for aboriginal health care. Do you think that would have made some sense so that you could have been assured of where you were going to be impacted or when that might take place?

Ms. Mandamin: That would have made a lot of sense two years ago, when the makeup was being developed, because you understand that First Nations are a very diverse group of people. There are jurisdictions that have to be respected. In much the same way, the Ontario Native Women's Association has to respect federal jurisdictions and provincial jurisdictions for on-reserve members that we represent. So in speaking on that purview, I really don't see that having been done by this process. It would have saved a lot of heartache and headache had the First Nations been respected in the first place.

The Chair: Thank you very much for your presentation.

We are going to have a break for lunch. We will be back here at 1, when we are going to hear from Dr. Ken Arnold and others.

The committee recessed from 1207 to 1303.

ONTARIO MEDICAL ASSOCIATION, THUNDER BAY CHAPTER

The Chair: Good afternoon. We will resume with the afternoon session. The first on the list is the Ontario Medical Association, Thunder Bay chapter, Dr. Ken Arnold. I believe there is also a second person. Have a seat, please, and start whenever you are ready. There is a total of 15 minutes available.

Dr. Ken Arnold: Welcome to Thunder Bay. My name is Ken Arnold, and with me today is Dr. Steven Harrison, director of policy at the Ontario Medical Association. I truly appreciate the opportunity to speak to you today about Bill 36, the bill that will make local health integration networks a reality in Ontario.

I'm a family doctor practising here in Thunder Bay. I sit on the board of the Ontario Medical Association and on that association's committee which has been following the development of the integration process. Today I'll outline my thoughts on how you might improve on this bill to make it better for Ontario's patients. I'll also outline a few particular issues relating specifically to the north. I'll be pleased to take any questions you may have following that.

To start, I must make clear how strongly Ontario's physician community wants this legislation to work for the betterment of health care in this province. Our patients are paramount. Any legislation that doesn't work to improve the situation for them would be a waste of time and money. Patients come first. Today, doctor shortages and wait-lists threaten the health and safety of our patients. Over 1.4 million people in Ontario do not have a family doctor. Our doctors are getting older, and many specialties are facing a 25% retirement rate in the next five years.

The government's plan for transformation, the plan that aims to improve the health care system in Ontario, is quite aggressive and has very short timelines. We, the physicians, sincerely hope to work closely with the government as the transformation happens across Ontario. Lessons learned from other provinces—Alberta and British Columbia, as well as others—and other countries in the world have made clear that doctors must play a key role in the management of health care at the local level.

Our experiences and perspectives are unique. Whether we work in a hospital, a clinic, an urgent-care centre, a mental health facility or a long-term-care facility, we all have important views to bring to the table. Perhaps more importantly, we have a vested interest in how care is managed. The better organized a system is, the better able we are to provide the quality of care that our patients need. Physicians need to be involved in the management and organization of health care where they provide it.

This said, I am asking today that you consider amending the legislation to mandate a formal mechanism for physicians to provide input to the LHIN decision-making process. Section 16 of the legislation allows physicians to provide input into a larger committee for health care professionals, the health professionals advisory com-

mittee. While the concept of such a committee seems appropriate, it's not anywhere near sufficient.

I'd like to make three primary reasons for this statement. First, the perspective of a physician is unique and valuable. Second, the voice of one physician on a committee of many health care professionals from across a large geographic area, as we face here, will not be adequate to ensure that all perspectives, all observations, all suggestions and all needs from the front lines are brought forward. Third, all other members of the health professionals advisory committee will be funded by money flowing through the LHIN. Physicians, on the other hand, will be independent of the LHIN in this regard. A separate committee would allow the physicians a unique ability to advise the LHIN without fear of accusations of conflict of interest. Most of the programs and services provided by LHIN funding will be accessed by our patients, usually requiring our approval to gain that access.

Given these points, a form of medical advisory committee that would report to the LHIN would work to ensure proper physician representation. I encourage you to look to Alberta's model to see how all health care professionals are able to report to their regional health authority and specifically how physicians provide input. Dr. Harrison is very familiar with this model and will be able to answer detailed questions should you require. I can tell you that Alberta's physicians work on official Alberta Medical Association committees locally. These doctors work with their members locally, are elected locally, and sit on the Alberta Medical Association council as well. The Alberta Medical Association worked very hard to get these local representatives in place and to get the notion supported by the regional health authorities.

There is also a physician representative who is paid a salary locally by the regional health authority and is called the regional medical adviser. This physician's role is to sit on the regional health authority board and provide information about how the planning is being implemented locally to the regional health authorities. They are responsible to the regional health authority and are paid by that authority. They are not linked with the Alberta Medical Association in any way.

The Ontario Medical Association is developing a model of local representation for physicians that will be applicable in Ontario's new integrated system. We'd be happy to share this model when it's finalized.

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Speaking now on issues directly related to the north, I'm sure you're all familiar with Mr. Tom Closson's report on integrated service for the northwest. This report outlines a potentially positive blueprint for the way the northern LHINs may operate, but there are inherent problems that I'd like to touch on this afternoon.

Mr. Closson suggested that the northwest could be divided into six regions within the LHIN to meet the need of administering the medical profession. By collapsing the medical advisory committees in the hospitals within each of these six divisions and forming a new

district MAC, the doctors would be able to have regional credentialing, regional on-call, and regional administrative roles. This may seem like a logical working plan; however, there are embedded challenges. First, this would require a significant change in the Public Hospitals Act. Second, doctors locally, as well as officially through our representative body, the Ontario Medical Association, need to be consulted. To date, this has not happened.

The report also suggested changing the categories of hospitals so that there would be local hospitals to support the local primary care initiatives, as well as district hospitals—the more recognizable acute care facility that we're used to in Ontario. Once again, input from the community and community practitioners would be needed. The issue here was process.

The Closson report, which was commissioned by the minister as an integrated service plan for northwestern Ontario, fails to allow these issues to be discussed with the LHIN in a formal way. These are the issues that are of primary importance to physicians and the patients they serve. The health professions advisory committee will not facilitate this, and there must be a physician advisory committee to give input into the discussion. The north has several unique and pressing needs that the LHIN will be unable to address without physician input. The LHIN process will not be able to deal with the issues of physician recruitment and retention or the dilemma of unattached patients, issues which have unfortunately been part of the culture of health care delivery in the northwest for too long. We will face the difficulty of providing specialist on-call coverage in areas where there isn't sufficient routine work to allow the physician to earn a livelihood.

As written, there is no mechanism for the LHIN to address these issues in the legislation. Physicians can bring these issues forward, and physicians are able to devise solutions. Our voice must be valued, and our voice must be heard.

In conclusion, I want to reiterate that we do want this legislation to work. Our goal is to assist in the successful integration of health care services in Ontario. We want to help create a system that is better for our patients. We must ensure that patient care is paramount, and access to care is not adversely affected. We look forward to working together to help ensure that Ontario's patients receive the best. They deserve it.

I'd be happy to answer any questions you may have.

The Chair: Thank you. We have about three minutes. Mr. Gravelle, do you want to start, please? One minute.

Mr. Gravelle: Dr. Arnold, good to see you, as always. Dr. Harrison, good to meet you earlier. Certainly, I appreciate your comments, particularly related to Mr. Closson's report that came out in terms of the need for more direct physician involvement. I was making reference to it several times this morning in terms of the expectations that we have in the northwest, particularly after Mr. Closson's report.

I am curious, and I appreciate your recommendation about the health professions advisory committee and your

belief that you need to have a more significant role or a more specific role. I know this has happened. You've been at other parts of the public committee process, and I presume you've had some discussions with the Minister of Health about this as well, at least some input from him. I would again make the presumption that he is giving some thought to your concerns. Is that fair to say? If there's time, I wouldn't mind hearing a little bit more about the Alberta model and how that works from Dr. Harrison.

Dr. Arnold: Dr. Harrison has been at some of the other meetings and perhaps could talk more about the minister's response. Certainly, he has been to Alberta to visit there. So I would ask Steven.

Dr. Steven Harrison: First of all, the minister has had multiple discussions with the executive offices of the Ontario Medical Association regarding the physician advisory committee. We had a meeting in December where we brought together about a dozen physicians, including Dr. Arnold, to meet with Ms. Paech and other ministry representatives to talk about the best way to go forward and ensure that physicians' voices are brought into the process. To date, there have been no decisions made as far as we know, but the conversation continues.

A little bit more on the Alberta model: There are two different tiers of this. Dr. Arnold alluded to both of them very quickly. There is an elected representative, elected by the physicians within the regional health authority, to represent them at the AMA council level, as well as within their region, to bring forward issues—whether primary care issues, acute care service issues, whatever—to the regional health authorities, to bring those issues up to speed for the CEOs of boards of those regions. As well, they have a forum where all of their regional health authority members, each one of those elected representatives, get together and discuss broader provincial issues that are occurring.

The second aspect of that is there is the regional medical adviser. That adviser is hired by the regional health authority and paid for by them. They do not usually engage in clinical practise; it's a full-time job. Their job is to go around and, as Dr. Arnold mentioned, take a look at how implementation of provincial and regional plans is going and then report back—they have fiduciary responsibilities—to the regional health authority board. They basically express how things are going and where changes need to be made.

Mr. Arnott: Just to follow up, I gather that the Alberta Medical Association is satisfied that those mechanisms provide them with an appropriate level of input to the regional health authorities?

Dr. Harrison: Yes, actually. There were five or six years at the outset of regionalization in Alberta where none of those mechanisms existed. It was chaotic, to say the least. There was a lot of turmoil between the ministry and the Alberta Medical Association, and between the medical association members and their regional health authorities. Once these instruments were put in place, I'm not going to say everything went away, but a good chunk of the turmoil started to diminish.

Mr. Arnott: It makes a lot of sense, but you're asking for something different. You're asking for a medical advisory committee, a separate committee to advise the LHIN, correct?

Dr. Arnold: You can put different names on it. "Medical advisory committee" is a difficult name because it has certain connotations within our hospital structures. Some people have talked about a local medical consultative committee, or name it what you will. Obviously, we would love to send 12 members to sit with the LHIN and discuss everything with them, but I don't think the LHIN board members might appreciate that.

Mr. Arnott: Not what the minister has in mind.

Dr. Arnold: Having a sort of pyramid, obviously, with someone to go forward and bring the information—

Mr. Arnott: That's the essential bottom line. Thank you.

Ms. Martel: Thank you for being here this morning. I wanted to talk about the Closson report, because it has been referenced here this morning. This Closson report was the way things were going to be in northwestern Ontario, and it's interesting that you pointed out that while it was commissioned for the minister, there is no mechanism to allow the issues that came out of that report to be discussed in any formal way in the LHIN. So where it will end up and what will happen to it remains very much to be seen. It is not a given that the LHIN will adopt it and adopt those recommendations.

Having said that, it's not clear to me that you want to see some of those recommendations adopted anyway, if I read correctly your point in the middle of the brief that says that the changes at least that were proposed for the MACs were changes that your local doctors had no input into. Am I understanding that correctly, that even though there was a proposal by Dr. Closson to have a more regional MAC for a number of hospitals, that was not something that came from local physicians?

Dr. Arnold: That wouldn't quite be so. The Hay Group obviously had an extensive investigation and talked to many people across the province. I think the concern is that, going forward, there's no mechanism under the LHIN process for physicians to be consulted about some of those important issues that need to be dealt with.

As a basic structure, Closson has some good ideas. The regional credentialing would certainly be helpful in a large area like this, allowing some more freedom for physicians to move around and help out. As a local physician is going on holidays in one town, the physician from the next town could more easily cover. That would all be useful. Our concern is the process here that doesn't allow the discussion to take place, because physicians need to be consulted going forward.

The Chair: Mr. Mauro, there is another 30 seconds. Go ahead.

Mr. Mauro: Thank you, Mr. Chair. I appreciate that.

Dr. Arnold, thank you very much for being here. I've just read your brief. Most of your concerns, of course, are around the physician's role in the LHINs themselves. I'm

just wondering if I could get a comment from you generally around what you think about the LHIN model as it's proposed. I had an opportunity to read a book by Michael Rachlis, the Prescription For Excellence. Are you familiar with the book?

Dr. Arnold: I haven't read the book.

Mr. Mauro: Okay. I think Dr. Harrison is saying he has. I read that book. He acknowledges that there is change required if we're going to sustain the system that we have, and he does talk about regional care authorities in his book and that the model has worked. I'm just looking for a general comment, beyond your specific concerns, about the model in general and whether you think it has a chance of success going forward to improve the system as we know it today.

1320

Dr. Arnold: I'll ask Dr. Harrison to comment specifically about Dr. Rachlis's comments.

Certainly, Ontario, as you know, is the last province, the last territory in Canada to adopt a regionalized approach, and although the structure in different provinces is not the same as is proposed here, nevertheless, as a representative from Thunder Bay, you will recognize that sometimes we have difficulty achieving and getting that connection with Queen's Park. I think that bringing things closer to home will be helpful to us all.

I know the provincial government often complains that the federal government doesn't give them enough money. I often worry that maybe the LHINs will end up complaining that the provincial government hasn't given them enough money and we're going into that tug of war all the time. But bringing things closer to home where we have a better idea of what's going on and how the money should flow I think will be very important.

Dr. Rachlis is bedtime reading for me.

Dr. Harrison: Yes, it's bedtime reading for me. Thank you.

The one fundamental difference of course between the RHAs that are discussed and the LHINs is that the RHAs are purchasers of services, so to speak, whereas the LHINs are supposed to be funders. It's just a transfer of the administration and the funding that currently exists in Ontario. That said, that may seem trivial to some people. However, that's actually a pretty fundamental difference.

To be honest, the design of the LHINs, as articulated in the legislation and previously through consultations and discussions, looks like it will have the potential to do a wonderful thing for Ontario. As I always say, it's how the rubber hits the road that makes the difference, and we don't really have something that we can truly reflect upon from elsewhere to determine whether this is going to be a good model or not. It seems as though it should work, though.

The Chair: Thank you very much.

CANADIAN MENTAL HEALTH ASSOCIATION, TORONTO BRANCH

The Chair: The next presentation is by teleconference, and I want to stress this. They were a group that

was listed in Toronto. Their schedule changed and because there was a cancellation, they are calling here from Toronto. That's why they're on the list. They are the Canadian Mental Health Association, Toronto branch. It's Steve Lurie, executive director. Mr. Lurie, are you on the line?

Mr. Steve Lurie: Yes, I am. Can you hear me?

The Chair: Yes, very well. You have 15 minutes. Please proceed.

Mr. Lurie: Thank you very much for accommodating me. I appreciate the opportunity to speak on such an important subject.

Just a little bit about our organization to get started: CMHA, Toronto branch, is part of the Canadian Mental Health Association, which is a national health organization. We provide a comprehensive range of community services to people living with serious mental illness. Last year, we served 2,158 people, with 157,450 client contacts. Eighty-five per cent of our funding comes from the Ministry of Health and is governed by a transfer payment agreement between our board of directors and the ministry. As an organization, we are strongly committed to collaboration and evidence-based care.

We welcome this opportunity to comment on the legislation. We're in support of the ministry's transformation agenda and hope that the LHINs are actually able to improve health care in the province. We also note that despite 20 years of government reports and task forces on mental health care in Ontario, we do not have an adequately resourced and linked mental health system across the province.

This presentation will provide commentary on a number of issues and themes in the legislation rather than a clause-by-clause analysis.

The first theme is community engagement. We believe that LHINs should facilitate systems thinking, not only for the health sector but also for subsectors such as mental health and addictions. With all the talk about integration of the larger health system, there's a risk that the system-building needs in both mental health and addictions will be ignored.

The requirements in the legislation for health service providers to carry out community engagement should focus on collaborative approaches to community engagement within subsectors rather than each agency proceeding on their own.

Let me give you an example. Here in Toronto, there are a number of geographically based mental health and addictions coordinating groups that could engage the public on issues such as access, comprehensiveness and quality of services. As well, each LHIN should ensure that they devote resources to provide a variety of means for consumers and families living with mental illness to participate in the planning and evaluation of mental health services.

I'd now like to turn to public interest. As you know, there is no definition of public interest in the legislation. We believe it should be defined as improving access to comprehensiveness, continuity and quality of health care. Where LHINs issue integration orders, they should

specify how the integration measure will improve health system performance in these areas. As well, they need to be objective about the limits to integration.

Pong and colleagues, in a paper commissioned by Health Canada, noted the following: "While service co-ordination is viewed often as the key to continuity of care, coordination also has negative effects.... Co-ordination may lead to the elimination of diversity of options for service delivery. In doing so, the process may rob certain patients of the benefits offered by some organizations. Some patients may be marginalized or excluded through the standardization of services."

This is a real challenge as we begin to do the planning in the LHINs environment to ensure that agencies that have a niche in the system, whether they're working with consumers directly as consumer-operated mental health service providers or agencies providing services to ethno-racial groups, aren't shut out of the process.

The third theme I'd like to talk about is the issue of a range of integration measures. As you know, the legislation defines integration rather broadly, and it gives the LHINs broad powers to transfer programs and merge organizations. However, there are many ways to achieve integration, and these include the development of assessment protocols, shared staffing, cross-training and consultation, the development of registries etc.

We believe that health service providers should communicate with LHINs about their integration plans. However, decisions that do not involve program or budget transfers should not require LHINs' approval. Many mental health organizations, for example, have a multitude of partnerships and inter-agency agreements. Requiring LHINs' approval for each one would bog the process down and could actually stifle integration activities.

There is a concern in our sector that mergers and transfers will become the default mechanism for LHINs, and this is despite evidence to the contrary. A number of public and private sector authors have shown that restructuring does not necessarily lead to improved performance at an organization or system level. "Private sector studies suggest that while mergers account for over \$3.4 trillion of annual economic activity, only about 20% appear to succeed." At the same time, the same authors, Grubb and Lamb, find that "there is evidence that strategic alliances and partnerships can be more successful at less cost."

Peggy Leatt and colleagues, who are from the University of Toronto health administration, have noted that "re-engineering is often unsuccessful in achieving the goals of organization change and caution that the 'business of health care is too serious to be managed or changed on the basis of trends.'"

"Mintzberg and Glouberman note that many countries are implementing administrative reforms in health care but there is very little effect on actual service delivery."

The implications of this mean that the integrated health service plans that are now being developed need to focus on incremental steps that can achieve real results in

terms of access and improved services within a three-year period, rather than grand schemes that could destabilize the sector and inadvertently lead to service reductions.

Donaldson and colleagues provided some very thoughtful advice in a review they did on international health care restructuring, which was commissioned by the C.D. Howe Institute. "They caution against implementing reforms without evaluation. 'Many of the reforms we have described'—as authors—"were introduced wholesale, without any thought being given to evaluation. This situation has contributed to the ambiguity of the evidence base.' They recommend a controlled pilot program and gradual introduction of reform. Interestingly, they find that in New Zealand and the United Kingdom, competition among providers has given way to co-operation, as the reforms have evolved." I think this is something we should be aspiring to here.

Perhaps the best way—can you still hear me?

The Chair: Hello? Did we just lose him? Sorry, can you get him back on the line? I was going to ask if there were any questions, but I guess he's not available.

1330

Mr. Lurie: I'm still here.

The Chair: Okay.

Mr. Lurie: Yes. I think I got cut off. Can I continue on?

The Chair: Yes. There are a couple of minutes left, sir.

Mr. Lurie: Let me focus on a few other issues. I'll provide a full brief on how to do the restructuring and some other references.

What I'd like to do now is turn to the notion of focusing on building system capacity. The Romanow and Kirby reports on mental health acknowledge that mental health and addiction services across the country do not have sufficient resources to meet population needs. Despite the investments during the last two years, which have led to some improvements, we need to be mindful of the recently published study by the health systems research unit at the Centre for Addiction and Mental Health, which noted that 55% of the clients of community mental health programs across the province were receiving one or more levels of care less than they required. Moreover, the study showed that only 0.5% of the population was accessing community mental health services when the target should be 2% to 3% for people living with serious mental illness.

Jurisdictions like New Zealand have set targets, protected and enhanced funding to ensure that their health authorities were able to ensure that, at a minimum, people with serious mental illness are able to access services in their communities. The provincial service integration plan must do the same if we intend to improve the access to and quality of mental health care in this province.

The Chair: Is that all, sir?

Mr. Lurie: No, just a few more things.

I think the other point I'd like to make is that in building system collaboration, we need to be mindful of ways to build connections across a supplier chain. So this would require that strategies be put in place to provide ways in which people can work together. In the automobile sector, which is not dissimilar to health care in terms of a variety of providers, supplier networks have the ongoing support of a supplier association, free consulting services, study groups, problem-solving networks, interfirm employee transfers and performance feedback. Similar strategies need to be developed by the LHINs to improve mental health and addiction systems. For example, New Zealand has set up a mental health development team in one of its health authorities to work with hospital and community providers to improve clinical practices and build linkages. As well, a development of client data linkage systems such as they have had in northwestern Ontario, where you now are, would be another strategic way to build systems integration while improving knowledge about client needs and the ability to access services.

Finally, I think we all need to beware the law of inverse relevance given to us by the Yes, Minister television series. It says, "The more we talk about something, the less we actually intend to do about it." We look forward to working with consumers, families, LHINs and our health care partners to develop improved mental health services in the years ahead.

The Chair: Thank you, Mr. Lurie, for your presentation. There is no time for questioning, but thank you again.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 822

The Chair: The next presentation has been moved an hour later, so we are going to the 1:45, which is the Canadian Union of Public Employees, Local 822, Kenora. Carol Favreau, please. Madam, you can start whenever you're ready. There are 15 minutes in total. Thank you. Good afternoon.

Ms. Carol Favreau: Good afternoon. Today I've brought with me Debbie Marcino, a fellow member of my support local—she's a medical secretary in my local—and my national rep, Danny Scheibli, to my right. You've got a copy of my presentation. I might skip over some parts of it.

I'm Carol Favreau, and I've worked in nutrition and food services for 18 years at Lake of the Woods District Hospital in Kenora. I represent over 170 fellow support workers of CUPE 822 who also work in and use the health care system.

Kenora is part of the largest LHIN geographically, stretching from the Manitoba border to past Manitowadge and up as far as Fort Severn. The proposed system as set out by LHINs gives people living within a LHIN little say over the direction of that LHIN, even if the LHIN board wishes to listen. With the bill, cabinet has the power to create, amalgamate or dissolve a LHIN. The

chances of a LHIN being made smaller are slim. For instance, CCACs are to go from 42 to 14. LHINs boards of directors, appointed by cabinet, are paid employees who can be removed anytime. LHINs boards are required to sign accountability agreements with the government—only a formality because the bill is set up such that the government can impose this even if the LHIN does not agree to the agreement. In addition, the LHINs integration plans must fit the provincial strategic plan. This makes LHINs boards responsible to government rather than communities.

Local hospital boards in the present system act in the best interests of their hospital and worked with the government to show them the consequences of proposed hospital cuts. As a result, decisions by government have been reversed and hospitals have been able to continue to provide decent, if still under-resourced, care. If we have problems with the way our health care is being delivered, who do we go to? Government will control the LHINs but LHINs will actually implement decisions. When people have discontent, they will first look to the LHIN boards even if the LHINs' power is really more imaginary than real. There is bound to be conflict for sure in our large LHIN over resource allocation, which will create dissension between one municipality and another, depending on who gets what for resources.

CCACs were taken over by government in 2001. Results were balanced budgets at the expense of thousands of frail elderly and disabled whose home support services were cut or lost altogether. Government-controlled agencies are poor models for health care and social service reform. CCACs have now been given more control, but this is all the more reason that the government-controlled model should not be applied now to the LHINs. LHINs directors should be elected. Boundaries of LHINs should further be explored through public consultation as well as proposed language about the government being able to amalgamate, dissolve or divide a LHIN. The ministry should consult the community prior to imposing an accountability agreement on a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-unionized employees.

Cabinet's authority to enact regulations closing LHIN meetings to the public should be eliminated. We need to ensure the right to seek reconsideration and for full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decision or regulation. Small communities, of which our LHIN has many, may be the first to see our services integrated with other communities. Anyone who has travelled the area covered by our LHIN can realize the problems this could create. We have limited train, bus and air services, as well as extreme weather conditions that make travel at times deadly. In our community, we use the Winnipeg health facilities quite often. For example, the daughter of one of my members was diagnosed with cancer. They had to travel back and forth extensively to Winnipeg. The

travel grants only cover mileage, so all of their hotels and other expenses were put onto them. Sometimes they stayed at great lengths in Winnipeg. So our community got together, did fundraisers and gave them the financial support they needed to cover their expenses. It makes it quite costly for us to use those facilities.

Section 25 of the bill gives LHINs the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service. Section 28 of the bill gives the minister even more power to order integrations directly. He could order a non-profit health service provider to cease operating, amalgamate or transfer all of its operations; for-profit providers are exempted from this threat.

Section 33 of the bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. This means the government can centrally dictate how all non-clinical services are to be provided by hospitals, including through privatization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There could also be considerable controversy because there is no definition in the act of “non-clinical service.” This bill paves the way for for-profit corporations, private clinics and regionally based support service providers.

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At the Lake of the Woods District Hospital, in at least the last 10 years, they have streamlined the way they deliver patient care. It makes no sense to further erode a hospital such as ours, which has gone above and beyond to deliver a balanced budget and still retain services. Its services are delivered in mostly one building, which is a valuable tool to the patients using the service. This seems more seamless than what the minister is proposing with this bill. Our community has rallied together to raise funds for such badly needed items as a CAT scan machine. This makes so much sense from a financial standpoint; as well, it's more humane to offer this service here than to transport, in some cases, very ill people as far away as Winnipeg, which is two hours away, to use their facilities, or Thunder Bay, which is six hours away.

Our support service workers have also been streamlined, mostly through attrition. They provide reliable, safe and efficient service. Many of the employees in our hospital are long-term, experienced workers who take great pride in their work because, up to this point, they have had a reliable employer who doesn't treat them like a disposable commodity.

Approximately eight years ago, the hospital had Versa foods come in and run our dietary department. They did not renew the contract with the company when it expired—the hospital found it more costly. They paid Versa to run the department, which included the cost of a manager; without Versa, they only had to pay the manager. At that time Versa came in, we went through a lot of layoffs, restructuring; we lost at least about five full-time employees in dietary alone. I'm only assuming that that was Versa's way of making a profit.

Integration will remove jobs and services from local communities, hampering access. Support services will likely be the first target. In our area, NOHBOS is already being explored. The committee has said this is voluntary at this point, but with LHINs, this could change. Centralizing services is the goal, but geography has been identified already as a problem.

The bill should provide:

—That cabinet, the minister and LHINs may only exercise their powers in the public interest, with “public interest” defined to include preservation of the public, not-for-profit character of our health care funding and delivery system.

—LHINs, the minister and the cabinet cannot order or direct integration, nor approve/disapprove integration. The power the LHINs have to withhold funding is power enough to encourage consolidations.

—The LHINs, minister and cabinet should not have the right to transform the health care system unilaterally; otherwise there is no reality to the claim that we are enhancing local decision-making and no point in retaining provider governance structure.

—The LHIN, ministerial or cabinet power to withhold funding to force integration only be exercised where necessary in the public interest and where integrated services remain publicly delivered on a not-for-profit basis.

—Transportation subsidies will be paid by LHINs if the required service is no longer provided in a given community. No purpose is served if integration creates new costs for residents.

—Nothing in the legislation authorizes cabinet, the minister or LHINs to override terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements.

—LHINs should be required by the bill to do an annual survey of unmet needs and to report unmet needs in annual reports to their communities.

Provisions should be placed in the bill that encourage or even require LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. The LHINs create a split between the purchasers of health care and social services and the providers. The LHINs will purchase services, and hospitals, homes, community agencies, and for-profit corporations will provide them. Such a split already exists in CCACs, which purchase home care services through a system of competitive bidding. This system creates unrest in both workers and clients they serve. Contracts come up for renewal, home care providers regularly lose contracts, and workers, who have no successor rights, are laid off. With this kind of job uncertainty, many workers look to be employed elsewhere.

My personal experience with home care: My father was ill about 10 years ago. He's passed away now. The home care support he had, he had the same home care person come in every day to help my mother. I've recently had to use the home support services since it's been changed, having to look after my sister, who was

terminally ill. They gave me four hours a day. They told me that was all they could provide. They said it would be pulled, though, if somebody else needed it more. My sister died last April. Excuse me for a minute; I'm sorry.

I saw big changes in the home care system when I had to use it, and it wasn't nice. I had three different home care people come into my home in one week. My sister couldn't get—I had to bathe her, and it was very difficult to have three different people all the time. They said they just didn't have the staff.

Privatization and decreased co-operation between providers are major threats of this reform. Instead of integration, privatization will bring disintegration, with the various providers in competition to win contracts. The institution of the purchaser-provider split and the expansion of privatization in health care and social services should not be a part of health care reform. We need a requirement that prior to developing a provincial strategic plan, the minister shall convene a province-wide consultation on the appropriate funding formula for the LHINs and the appropriate funding formula for each of the health service provider subsectors. Competitive bidding models should be specifically excluded in the legislation, based on the disastrous results they have already brought to Ontario health care.

Changes in health care delivery contemplated by these reforms open up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act to many of the potential changes in employment that could result. Workers faced with this change deserve, at a minimum, a fair process providing reasonable employment security, protection of working conditions, collective agreements and bargaining unit rights.

CUPE is closely examining the impact of Bill 36 and its use in some cases of the PSLRTA to deal with the labour relations issues raised. I'm just going to touch on a couple of the points we would like provided in the bill:

Provide in the bill that the PSLRTA applies regardless of whether a person or entity is a health service provider and regardless of whether the primary function of the person or entity is to provide services to the health sector; and

Employees should continue to be governed by their existing collective agreement and conditions of employment, and these continue to be determined through central bargaining and HLDAA.

Thank you for listening to our concerns and suggestions.

The Chair: Thank you for your presentation. I'm sorry about your sister and father. There's no time for questions, but thank you again.

ONTARIO NURSES' ASSOCIATION, LOCAL 81

The Chair: The next presentation is from the Ontario Nurses' Association, Local 81, Thunder Bay; Judith

Carlson, local coordinator. Please have a seat. There are 15 minutes to use as you please.

Ms. Judith Carlson: Good afternoon. My name is Judith Carlson. I'm the local coordinator for Local 81 of the Ontario Nurses' Association. With me today is Marc Young, one of our provincial communications officers.

I've been in nursing for 35 years. I have worked in pediatrics, med/surg, geriatrics, intensive care and, for the last 20 years, in emergency nursing. For all those years I have worked at Lake of the Woods District Hospital in Kenora, and for 10 years I did air medevacs throughout the north as well as nursing, and so I have an understanding of the problems we have with air transport.

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Let me start by telling you that there are 4,500 ONA members in the Thunder Bay area—which we refer to as region 1 in our structure—and the surrounding local health integration networks or LHINs. We have registered nurses and allied health professionals working in all sectors currently included under Bill 36. There are hospitals, community care access centres and long-term-care facilities. We also have nurses in public health services, which, as you know, are currently not included under Bill 36.

The committee has heard from ONA leaders in Toronto, London and Ottawa over the last three days. I'm sure it's been a whirlwind journey for you, and thanks for coming to the north.

We've heard a number of key reasons why ONA does not support the current approach to integration as set out in Bill 36. Nurses in the Thunder Bay area are looking for genuine integration from this round of health reform. We want to see health services integrated, so that our patients have ready access to a seamless continuum of care and a system where our professional practice can flourish.

I should tell you that I was the ONA board representative for this region back in the mid-1990s, when ONA was recommending principles for integration of health care. I spent many days—more like weeks—trying to envision what integration would look like in this area. Because of geography alone, I knew it would be very different than integration in southern Ontario. So I have a long history and interest in getting integration of northern health services right. However, we don't believe that Bill 36, as currently drafted, provides the underpinnings for an integrated health system.

LHIN number 14 is 1,000 miles wide and probably that far from north to south. Services must be delivered in many small, remote communities. The vast distances between major centres make integration of services virtually impossible. In the 140 kilometres between Kenora and Dryden, there is only one village and the road is often closed for long periods, whether for bad weather or motor vehicle collisions. This is also the case east of Thunder Bay. There's only one road and no alternative route.

Many of the communities in the north already have a version of an integrated network. Often many of these

services are run out of, or by, the hospital. This is because the hospital recognized the need and there are no other services or service providers available in the area.

The provincial government has developed a fact sheet in response to the concerns that are being raised about the approach to integration in Bill 36—what they call “myths.” I’d like to spend the rest of the time with you to review why we believe the government’s interpretation of Bill 36 does not address our concerns with the approach to integration being presented. Nurses are not making up concerns about Bill 36. We don’t have time to sit around imagining what might happen. These concerns are not myths; they are based on our experiences.

Bill 36 is all about giving power to unelected boards mandated to identify duplications and concentrate services in particular centres and facilities. The government claims it is a myth that LHINs will mean less access to health services and services being moved further away from our community. But one LHIN chief executive officer, for example, even told a public meeting in Sarnia that in the new age of health care, residents of that city should get used to the notion of travelling to Windsor for certain services. It would be much further in the north. Is this a myth? Nurses don’t think so.

Is it a myth that LHINs are not sensitive and responsive to local health care needs? The government argues that it doesn’t make sense to micromanage an enormous health budget from head office and that local communities have a better sense of their own needs. So why didn’t the government let the communities elect their own LHIN boards? Rather, head office made the selections. What is local about boards assigned to meet the health care needs of populations larger than the province of Saskatchewan?

Moreover, the government can close LHIN board meetings to the public when it wants to: not much sensitivity or responsiveness there. The rationale from the government is that other provinces have moved to undemocratic boards. That’s no reason for us to do the same in Ontario. I was told that we would learn from their mistakes. This obviously isn’t happening.

LHINs will open the door to privatization. The government denies this, stating that the legislation prohibits any integration that would cause an individual to be required to pay for health services. But in the ministry fact sheet they forget to add the clause, “except as otherwise permitted by law,” which in Bill 36 follows the guarantee that patients won’t have to pay. The bill also encourages service providers like public hospitals to integrate their services with “those of another person or entity,” with no restriction on whether those entities are for-profit operations. This means that procedures and jobs will be moving to doctor-run clinics, perhaps. Finally, the bill allows the government to order a public hospital to transfer its non-clinical services to an enterprise of the government’s choosing.

LHINs mean job loss and lower wages. Not true? Just ask hospital workers whose jobs have already been contracted out to private firms. Not only do they work

with lower wages, but they’re allowed to have less job satisfaction. Our nurses and health care professionals who worked in home care saw their wages and benefits fall when the competitive bidding model pushed non-profit agencies like the Victorian Order of Nurses out of the sector.

The plan lacks a comprehensive plan to deal with employees in any way that protects jobs and improves patient care. The government calls this a myth, but partial and total mergers of health care employers will be ongoing. As the bill stands now, workers who after a merger find themselves employed by firms that are not primarily health care providers will likely not have their pay and benefits protected. Patients will be served meals and depend on laundry services provided by companies determined to cut costs so as to protect their profit margins. Patients who need more nurses and other health care professionals may well see fewer staff as the LHINs pressure hospitals and other providers to economize.

LHINs reduce accountability by placing decision-making at arm’s length from the government. With the new scheme, who is accountable? The Minister of Health will be shielded by a new layer of bureaucracy—just what we don’t need. Meanwhile, how is the LHIN accountable to its community? The members of its board serve at the pleasure of the government, not of local residents, and accountability agreements between LHINs and health service providers are not guaranteed to be disclosed to the public. The result? Reduced public accountability.

LHINs ignore the role of doctors. This is not a matter of interpretation: The legislation excludes physicians. LHINs will not fund doctors’ salaries. This is curious insofar as one of the board’s key mandates is to achieve economic efficiencies in a system where the key cost driver is income paid to the doctors. So while it might be defensible to say that LHINs don’t ignore the role of doctors, the legislation certainly doesn’t take physicians fully into account, or perhaps the government took doctors’ opinions entirely into account when it kept them outside the LHINs scheme.

LHINs take away local control, and there is no input from front-line staff. Is this a myth? Let’s investigate. The provincial government appoints boards accountable to Queen’s Park that will have the power to move services. For example, when birthing facilities and other procedures are moved away from smaller communities and concentrated in regional centres, it is fair to say that the local control is being undermined.

As for input from front-line staff, each LHIN will be obliged to establish a health professionals advisory committee, but the legislation fails to guarantee that those members of the regulated health professions appointed to these committees will be representative or have meaningful input and disclosure. It doesn’t sound like a myth to us.

LHINs have the potential to extend the competitive bidding model to the entire health care system. LHIN boards are mandated to economize when encouraging or

ordering public hospitals to carry out full and partial mergers with other health care providers. Services will move out of hospitals to the extent that alternative providers are able to offer them at a lower cost. Despite its disastrous effects on home care, this government has seen fit to continue competitive bidding in this sector, nor does Bill 36 exclude managed competition. In short, the evidence suggests that concerns on this front are far from mythical.

There has not been extensive consultation on LHINs. There have been workshops, as the ministry asserts, at which information has been woefully inadequate and where government officials have done their best to conceal the main ways in which the piece of legislation, as it is presently written, will undermine patient care and bring chaos to the health care labour market in Ontario.

1400

First and foremost, nurses are concerned about the lightening speed at which the government is rushing towards the implementation of massive change to our health care system without extensive consultation and without a provincial strategic health plan. If you fail to plan, your plan will fail. Let's stop right now. The government must issue a green paper and conduct extensive consultations. Nurses will then work together towards a real reform for a genuine integrated health system.

Thank you.

The Chair: Thank you for your presentation. There is no time for questioning, but we thank you.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 720

The Chair: The next presentation is the Ontario Public Service Employees Union, Local 720, Thunder Bay: Doris Meredith. Good afternoon.

Ms. Doris Meredith: Good afternoon. My name is Doris Meredith, and I'm with OPSEU, Local 720. I'm sitting with John O'Brien, who is our regional vice-president.

I'd like to thank you for the opportunity of being here today to speak to the issue of LHINs. I'm a local president at Lakehead Psychiatric Hospital, where OPSEU represents close to 450 nursing, paramedical, professional, and service and clerical staff. I'm also vice-chair of OPSEU, sector 18, which represents approximately 8,000 OPSEU employees who work in the mental health sector in Ontario.

I'm presenting today with the hope that you'll be able to use your discernment of the issues presented today to guide the construction of a legal framework that will preserve certain principles of health care delivery within the 14 regions of Ontario. Northwestern Ontario has a very unique geographical and demographic makeup. I trust that other presentations today have or will provide you with a snapshot of the unique challenges we face here.

Because of time constraints, I've limited my presentation to address one area of process, specifically regard-

ing the priority-setting of the LHINs. I will also address issues of employment stability and briefly speak to the challenge of the importance of constructing the legislation to protect access to mental health services in the province.

My concerns regarding process speak to the illusion of local or regional input into health service provision. I've been following the progress of transition to the LHIN system since the concept was first introduced in late 2004. At that time, community agencies and health service providers were invited to participate in workshops, namely the "Taking Stock" initiative of setting integration priorities in the 14 LHIN regions.

The northwestern Ontario workshop was held in Thunder Bay on December 10, 2004. Two hundred and sixty-six representatives of health service providers participated in the workshop. The group identified 38 integration opportunities and subsequently prioritized the top five patient care and the top five administrative integration opportunities for this region.

My specific concern is that during the workshop, the proposed Bill 36 legislative framework was unavailable to participants. The LHIN concept was referred to as a work in progress, and participants were told to get on board or get left behind. At the time that the workshop participants formed their ideas for integration opportunities, they did not have access to any form of the proposed legislation.

In region 14, only three labour representatives from one union were able to participate. Those participants, of whom I was one, also had not seen the legislation before us today. What was disconcerting to me at the time was that the labour organizations were not invited to participate during the early public consultation phase of the LHIN initiative. OPSEU was able to participate only because of a very perceptive staff that was paying attention to the issues of health care.

The reason unions were not specifically invited subsequently became apparent once the draft legislation, Bill 36, became public on November 28, 2005.

My point is that the absence of any knowledge of the legal framework of the new system during the public consultation phase will cause a two-pronged problem. On one hand, health service providers could not have anticipated the impact of the legislation on the provision of health services during their priority-setting exercise. If they had had access to the legislation, their priorities may have been different. This will cause the public consultation phase of the LHIN initiative to be skewed from its inception.

Secondly, if Bill 36 passes as it is, there is no way to unring the bell. The priorities for regions have already been established under this process and are slated to be passed on to the new LHIN boards. There are no provisions in the legislation to undo this portion of the public consultation process, and there is no provision in the legislation that ensures future public consultation.

Now to my concerns about the legislation itself. As an employee and local president of one of the former provincial psychiatric hospitals, I have gained first-hand ex-

perience of the sense of confusion and instability that employees feel when they're involved in system integration. Despite the sense of insecurity employees felt during the divestment process of the provincial psychiatric hospital from the Ministry of Health to the broader public sector, employees at Lakehead Psychiatric Hospital were able to rely on collective agreement provisions to assist them throughout the transition process. In addition, these employees had access, under the Ontario Labour Relations Act, to other provisions that allowed for employment stability.

The voluntary recognition provisions of the Ontario Labour Relations Act were applied in our case, as there was no intermingling of bargaining units. This allowed the union and the employer to negotiate an agreement that maximized employment stability for employees in the bargaining unit and has allowed the employer to retain its specialized workforce. This has resulted today in better patient care for our community. The same outcomes for staff and employees may not be possible if Bill 36 is passed in its present form.

Negotiations between unions and employers establish a legal framework for workforce stabilization. The most fundamental labour relations implication of this legislation is the proposed extension of the application of the Public Sector Labour Relations Transition Act, 1997, to a LHIN integration decision. Under Bill 136, the OLRB had the discretion to order votes only where there had been the intermingling of employees. If Bill 36 passes unamended, it may lead to a representation vote whenever health system integration occurs.

By giving itself sweeping powers to enforce integration decisions and ministerial orders by applying to the Superior Court of Justice for an order to direct parties to the integration orders to comply, which is found in subsection 29(3) of Bill 36, the LHIN may be able to override existing collective agreement provisions that address employment stability. This will cause radically restructured bargaining units, even when the employees have remained separate and apart. This will undermine continuity in the provision of services and force service providers to be continually training and orienting within other organizations. Not only will health service providers have to deal with these issues; they may also immediately be involved in layoff situations and will face legal challenges regarding notice and severance under the Employment Standards Act. Legal wrangling to deal with these issues will divert attention and precious health care dollars away from health service provision.

If competitive bidding by single-service providers is added to the mix, stable employment will become a product of history only. This employment environment will undermine the stability of whole communities as people are forced to move to other areas of the LHIN region where services may become consolidated. Where two income earners cannot work in the same community as a result of an integration order, families will be torn apart.

Lastly, I'm concerned that mental health services will be particularly hard hit by this proposed legislative

framework. Mental health services have often been referred to as the poor second cousin of health services in general and have had to struggle to obtain sufficient funding. By having a LHIN allocate funding for these services from a global health funding envelope, these services will be put further at risk when facing intense competition for funding against other health services in general. Mental health funding must be protected in an amended Bill 36, in order to allow for the discussions that need to take place to establish adequate access to mental health services in the LHIN regions.

1410

This has been my attempt to inform your recommendations for amendments to the legislation before you. In this regard, I respectfully request that the standing committee on social policy make recommendations that will amend Bill 36 to guarantee:

(a) fully informed comprehensive community involvement in LHIN priority-setting and accountability of the LHIN to the public;

(b) a framework for negotiations between employers and bargaining agents that maximizes opportunities to maintain employment stability; and

(c) a separate funding envelope for mental health services.

I just want to speak to this one quickly. I'm not proposing a model; there are far more articulate people who can speak to this piece. But what has become apparent is that mental health services funding does need to be protected, and we're certainly advocating for that.

Referring back to the priority-setting phase of the LHIN initiative, and emphasizing the point that participants did not know about this proposed legislative framework as they developed priorities for integration in this region, please consider the following quotes that came out of those workshops:

"Ensure that there is a continuum of care that is client-centred."

"Ensure ... access to needed services in a timely manner ... sufficient funding ... support client in setting of choice and ability...."

Finally, "Integration does not mean amalgamations and mergers. Integration means partnerships, collaboration ... appropriate use of existing services."

The Chair: Thank you. We've got just under three minutes, so we'll take a minute each. We'll start with Mr. Miller.

Mr. Miller: Thank you for your presentation. We had an earlier presenter from the Canadian Mental Health Association. They are afraid that the LHIN model is going to mean more or less what you said, that mental health will be competing against other health care needs like cancer care etc. Their concern is that funding for mental health will be reduced. Is that what you are also concerned with?

Ms. Meredith: Yes, I'm very concerned about that. A lot of excellent work has been done by committee after committee. There have been the North West Mental Health Implementation Task Force studies; there's been a lot of work done that I think is just sitting on the shelf at

this point. The recommendations that have been made have been essentially around retaining some sort of control over mental health funding so that services can be rationalized within a system, but within the mental health system itself.

Ms. Martel: Thank you for making a presentation today. I just want to go back to the meeting that was held in December 2004, when all these groups came together. Was there any information given to participants at the time that local control was going to mean people who were essentially appointed by the province? Was there any discussion about who was going to be involved in this and how they were going to be appointed?

Ms. Meredith: There was an information booklet that was handed out, and it did show a LHIN structure. There was a question-and-answer period at the meeting, where people were trying to get answers to those types of questions. But the message that was going out was, "This is a work in progress. We don't have those answers right now. When we have them, you'll find out."

Ms. Wynne: Thank you very much for being here. The reality is that at that time those decisions probably hadn't been made about what was going to be in the legislation. The minister was meeting with a number of people, including—before those meetings, he had met with Leah Casselman. He's talked to many folks from the sectors around the province.

One of the things I wanted to ask you is, those comments that have been made in various reports and various forums are really important in terms of informing this process going forward. So when in the legislation it states that the LHINs must involve themselves in community engagement and public engagement, how do you see that best happening so that comments like "Integration doesn't mean amalgamations and mergers" don't get lost, that those comments continue to be made? How do you see that public and community engagement happening?

Ms. Meredith: I think it may be very important at this point to hold back on the implementation of the legislation. Once the legislation goes through—if it isn't amended and it goes through as it is, any community consultation after that point may not have the result that people would like it to have.

Ms. Wynne: Except that as the LHINs do their work and identify gaps and come up with the local plans, they're going to need to keep talking to people in all the different parts of the province. I guess I'm just asking you to think about it, because we're going to run out of time. But if you have suggestions about particular mechanisms you think LHINs should be using over time, that would be very helpful.

The Chair: Thank you very much for your presentation.

KENORA HEALTH COALITION

The Chair: We do have the Kenora Health Coalition on the line, so we are going to hear the presentation from Cassandra Moeller, co-chair. Cassandra?

Ms. Cassandra Moeller: Hi there.

The Chair: Good afternoon. Please start your presentation.

Ms. Moeller: Okay. Thank you very much. My name is Cassandra Moeller, and I'm the co-chair of the local health coalition here in Kenora, the Kenora Health Coalition. This is a community-based coalition. Our primary goal is to empower members of our community to become actively engaged in the making of public policy on matters related to health care and healthy communities. We seek to provide our community with ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of our system of checks and balances that is essential to good decision-making.

We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly funded, publicly administered health care system. We work to honour and strengthen the principles of the Canada Health Act. The Kenora Health Coalition has members who are seniors activists, union members and community members at large who are concerned with the state of health care and, worse yet, the apparent move away from the publicly funded, publicly delivered model of health care.

As a coalition, we lend our support to many other community health projects and groups. Some examples of our coalition's representation are the family council at the Kenora District Home for the Aged, our commitment to the Kenora Health Providers Group and the Kenora Seniors Coalition.

Health restructuring: This legislation appears to be a health restructuring act. Like the hospital restructuring act legislation brought in by the Conservative government, this bill increases the health minister's and their designate's power over health providers in order to facilitate restructuring. Like the Conservative government's restructuring, there are only a few, if any, checks and balances to ensure that population need and the principles of the Canada Health Act guide this restructuring.

There has been no evaluation of the consequences of the last round of restructuring, save the reports by the Provincial Auditor that expressed concern about the sequencing of restructuring, the lack of projected savings and the costs, which escalated to \$2.8 billion over planned amounts. By the end of the last round of restructuring, hundreds of millions in operational funding was spent to close hospital beds, cut programs and lay off health care staff.

We strongly encourage the government to take heed of the effects of the former government's attempt and large failures prior to continuing to push through this legislation. During its tenure, the Conservative Health Services Restructuring Commission issued final directions to 22 communities, affecting 110 hospitals. These directions amalgamated 45 hospitals into 13, and closed 29 hospital sites. The worst years were from 1995 to 1997 and im-

mediately after, when the Conservative government withdrew approximately \$900 million without warning from the hospitals, announced closures and amalgamations of dozens of community hospitals, and forced the cutting of 9,000 critical, acute and chronic care beds and the layoff of approximately 26,000 positions.

1420

Hospitals were thrown into chaos with amalgamations, bed closures, staff cuts, emergency room overloads, and serious backlogs for procedures and diagnostic tests. Hospitals drained their reserves as they attempted to cope with the serious funding shortfalls.

Community services did not exist to take the load of acute patients moved out of hospitals. Slowly, new long-term-care nursing home beds and home care took many, but in the process, support of home care services to tens of thousands of frail elderly seniors were cut, as they were pushed to the bottom of the priority list in a competition for scarce resources.

Ultimately, the Conservative government was forced to re-fund hospitals, but seniors' services in the communities—off-loaded hospital services such as physiotherapy, speech pathology, social work and others—have never been restored.

The new capacity in the health care system, new long-term-care beds and the extended home care program for acute patients were largely given over to for-profit companies. After spending billions, the last round of restructuring increased privatization, created massive labour disruptions, and reduced the scope of publicly covered services.

New powers: In Bill 36, the Ministry of Health and Long-Term Care has given itself, and essentially controlled LHINs, major new powers to order health system restructuring and contracting out. The main new powers include:

- the ability to order transfers of service, personnel, property and funding, with limited appeals and compensation;

- the ability to order closure, merging and transfer of all operations from many non-profits but not for-profit, service providers;

- enforcement of these new powers by court order;

- a new structure for the health system ruled by the health minister's strategic plan, set out unilaterally, enforced ultimately by court order;

- the ability to override protections and provisions in legislation covering civil servants, corporations, expropriations and the statutes act, among others.

This legislation appears to be a bill to empower the ministry directly and through LHINs to execute a new restructuring of the health system. The legislation confers powers that expressly override previous legislation that set out processes for the disbursement of charitable and non-profit property, the guidelines of the civil service compensation for expropriation of property or process for the enactment of statutes.

While this government obviously trusts itself with these increased powers, we wonder, would it trust a

future government run by another political party with these powers? Despite claims by the ministry, this legislation does not set up regionalized health care to move control closer to communities. In fact, this legislation centralizes power rather than regionalizing it.

The LHINs are to be made up of government appointees, with the purpose of reorganizing the local health system based on targets and goals set out by the LHINs under the direction set by the minister. The LHIN boards are entirely undemocratic. They are appointed by cabinet and can be replaced at cabinet's will. The qualifications for these positions are biased towards business and administrative elites, and there are no provisions in the legislation for diversity, democracy or representation. There is no protection for equality-seeking groups. Cabinet is given the inexplicable power to exclude any persons or classes of persons from LHINs membership.

There are no protections in the legislation to prevent a revolving door between the for-profit health industry and the LHINs. There are no normal, democratic precautions and processes set out in the legislation. There is inadequate specification of an expected process for public notice of meeting. The bill simply requires that notice "be given in a manner that is reasonable in the circumstances." Most non-profit and other organized groups require a certain level of publicity for public notice of meetings.

There are no normal democratic protections against in camera or secret meetings. The bill gives cabinet discretion to regulate what will be in camera or not. This is not in keeping with the legislation covering comparable regional government organizations, such as school boards and municipalities, that are bound to short-term lists of items in legislation for which they meet in camera. Why does this government envision a system in which democratic rights regarding the health care system are less than they are in other sectors?

There are no public processes for access to timely information regarding restructuring proposals, and there is no process for public input or appeal. Even the Conservatives' health restructuring process allowed for public deputation. Anyone can make a submission. In this bill, the public will be able to access restructuring orders at the LHINs office after decisions are made. No patients or community members have the right to appeal.

There is no democratic process regarding the minister's strategic plan for health. Normally, a change in the strategic direction of the entire ministry, covering a vital service like health care, would include a white paper or similar document, setting out the intended strategic direction, issued publicly. There would be a broad consultation which would be on the record and available for public perusal. The result of this consultation would be used in the creation of legislation or directions flowing from the white paper. This legislation describes a process in which the minister, without any consultation process or any public input on the record, will set out the strategic direction for the entire health system and implement it, backed by court order.

Privatization: The legislation facilitates privatization in several ways. The LHINs may move funding, services, employees and some property of non-profits to for-profit agencies. Cabinet may order the wholesale privatization or contracting out of all support services in hospitals. Note that there is no definition in any Ontario legislation of what constitutes non-clinical services. Under this legislation, cabinet is given the power to define these services as broadly or as narrowly as they wish. The minister may close or amalgamate non-profits but not for-profit companies. It is not difficult to foresee a shrinking set of non-profit providers while the for-profits continue to gain new market opportunities as the system is restructured. There is nothing to prevent the moving of services out of hospitals, where they are covered by OHIP, into the community or other facilities where the government is allowed, by law, to make people pay out of pocket for them. There is nothing to prevent them from cutting services so that people must pay out of pocket for them.

The new use of powers contained in the legislation will likely become clear when the minister makes public his strategic plan for the health system. Under this legislation, the LHINs are required to execute their powers following the direction of the strategic plan set out by the minister. They will be bound to do so by accountability agreements with the minister. There is no process of public input or debate to precede the setting of that strategic plan. It will be publicly available once it is set. However, in speeches and interviews, the direction of the minister has become clearer.

Competitive bidding in hospitals is a major concern. It is the current direction of the ministry to expand a price-based competitive bidding system through acute-care hospitals. Thus, for example, the regional hospital that bids under a centrally set target price for the hip and knee replacement surgeries would get the funding for that region, and patients would be required to travel further to access health services.

Under this legislation, the LHINs would have the power to allocate funding, and therefore services, to hospitals that underbid others. While many civil-minded community members have been fundraising for generations to improve local access to services, the direction of this ministry is the opposite: to coordinate services into the hospitals that specialize.

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The ministry has also mentioned in several speeches and interviews the number of mental health community agencies. This legislation gives the LHINs and the government the power to order the amalgamation or closure of these agencies. This system of market competition that has been so destructive in home care is already being introduced in the hospital sector under the guise of "wait-time strategy."

The ministry surveyed hospitals to find out prices for cataract surgery. It then set essential targets and funded those hospitals that provide the surgery at that price. Reduction in the price target is the next goal.

The Chair: Thank you. Madam Moeller, you've used your 15 minutes already. Do you want to conclude, please?

Ms. Moeller: Of course. These LHINs are very worrying for the local area because our LHIN is so geographically large and serves such a diverse population. I request that the government take that into account and implement suggestions for more democratic input.

The Chair: Thank you. I understand that you are going to fax your presentation to us. We thank you for that and for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1781

The Chair: The next presentation is from the Canadian Union of Public Employees, Local 1781, Kenora: Judy Bain. Good afternoon, Ms. Bain. You have 15 minutes. Please start when you're ready.

Ms. Judy Bain: Hello. My name is Judy Bain. I'm an RPN and I work at Lake of the Woods District Hospital. I've worked as a nurse for 20 years. I'm the president of CUPE Local 1781, which represents the RPNs at our hospital.

I would like to start my presentation with a quote from George Smitherman, Minister of Health, from his speech to the Ontario Hospital Association, November 5, 2003.

"Restoring the pride and confidence of our front-line workers is an important test, and something I will treat as an early priority. And better working conditions are part of that equation."

"Health care is delivered by people—and it's our job to make sure that they have a safe and supportive working environment."

Well, Mr. Smitherman, those are pretty words, but this government hasn't restored any confidence in the front-line workers. All this government has done is it has broken promise after promise for health care workers. P3s, AFPs, more nurses—all empty words.

In regards to the LHINs, I'd like to say thank you for your 15 minutes of time, but it angers me that this standing committee is in Thunder Bay and not in my home community of Kenora. Many people would have liked to have a say here today, but to travel to Thunder Bay is a six-hour ride from Kenora or a \$1,100 flight. Many seniors can't afford this. In our town hall meeting last Thursday, they had a lot of concern and a lot of questions. If this government was really interested in consulting the public about this, they would have put this committee in rural communities and not in urban centres. I think it's kind of ironic that the hearings are all in big centres. I have a feeling that this will be very similar to how the LHINs are run: Rural communities will suffer and lose their voices, and the urban centres will be just fine.

The only thing local about the LHINs is the name. Our LHIN is very big; it's vast and it's diverse. Northern Ontario has a hard time catching the ears of the government at the best of times, so having a LHIN this

big is very alarming. The boundaries have been formed based on hospital referral patterns, overriding municipal and provincial boundaries. This bill would grant very little real power to local communities and providers to make decisions that affect their communities. How can local hospitals stay connected and best serve the communities when they are mandated by LHINs? So it will be very difficult for people living within the LHINs to have a significant voice over the direction of the LHINs even if the board wishes to listen to them.

The LHINs will operate like regional ministries with awesome powers, heavy administration requirements and very little public accountability for improving the health care system. What is the role of the local hospital boards that are now currently elected? Now taken over by government-appointed and unaccountable people. The government will control the funding, and each LHIN will be required to sign accountability agreements with the government. How do we make the government accountable when they will unilaterally impose agreements if the LHINs don't agree?

If the government wants to restore confidence in the front-line workers, they could start by making the amendments needed to ensure our work will not be contracted out and privatized. Give us specific guarantees in legislation on competitive bidding and privatization. Also, employees should continue to be governed by their existing collective agreements and conditions of employment, and these must continue to be determined through central bargaining and HLDAA. Existing terms and conditions of employment set out in the collective agreements should be respected and not steamrolled by the government, with no respect for them.

The integration will remove jobs and services from local communities, hampering access. Support services will likely be the first to go, but I do believe clinical care will be under attack. There is no protection against OHIP service being cut. In fact, the LHINs may isolate the minister from political consequences of such cuts.

There are no provisions in the bill which ensure, require or encourage the LHINs, the minister or the cabinet to preserve a public, not-for-profit health care system. I believe these bodies will now be able, with legal authority, to privatize large parts of our publicly delivered health care system. An interesting note: The Liberals campaigned in 2003 on keeping health care public and stopping the creep of privatization that they cited and criticized during the days of Mike Harris. Well, Mr. McGuinty, it looks to me like you're turning blue.

Why weren't the health care act principles of comprehensiveness, universality, accountability, portability and public administration included? The lack of clear direction or principles to protect public interest is a deep concern, since recent speeches and interviews by the health minister indicated that his strategic direction is to centralize and consolidate hospital services and community health services.

Under the provincial wait time strategy, the minister is implementing a competitive bidding system for hospital

services such as cataracts and hip and knee replacements. We have reason to believe that this will be even further expanded under the LHINs. This bidding system is structured to result in fewer hospitals delivering these services, worsening the inequities of local access to these services. We have just started doing eyes and knees in our hospital, and we don't want to lose these services. They are very important to the citizens of our community.

To sum up my thoughts, I believe this bill and the government's attempt to restructure health care needs to be rethought and move at a much slower pace, with more input from all sectors of health care and the consumers of this system. The rush to push this bill through has left many people wondering about the hidden agenda of the Liberal government, and that is where credibility is very fragile.

I now have some questions I would like to ask the committee. I would like you to define "community" for me.

The Chair: Anyone?

Ms. Bain: It doesn't matter.

The Chair: Does anybody wish to answer? Ms. Wynne?

Ms. Wynne: The way "community" is used? Are you talking about the section where we talk about community engagement?

Ms. Bain: Yes. I'm just curious when you say "community."

Ms. Wynne: It includes the community of people who are involved in health care as well as the public.

Ms. Bain: So the total LHINs.

Ms. Wynne: Sorry?

Ms. Bain: When you engage the public, are you talking—

Ms. Wynne: It's a requirement in the legislation that the LHINs engage the public, engage the community, in their processes, in their deliberations.

Ms. Bain: Okay. My second question is, do you see further amalgamations of the LHINs, going from 14 to 7 or—

Ms. Wynne: Well, in fact, there's a mechanism within the legislation that would allow more LHINs to be created. If it's determined that there are too few and there's a need for more than there are already, then that can happen. So that's an ongoing process.

The Chair: Before you go ahead, Shelley Martel, please.

Ms. Martel: Yes, there's a provision in the legislation that says that the minister can increase or also can dissolve some of the LHINs. So there can either be more or there can be less. The provision exists for both possibilities.

Ms. Bain: My third and final question is, will the referral patterns be a part of the written agreements to honour current practices? We do a lot of our transfers into Manitoba, and I'm just wondering if it's the intention of this LHIN to continue to honour those practices.

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Ms. Wynne: Yes, it's my understanding that those referral patterns, first of all, were part of what determined the way the LHINs were set up and that they would be ongoing considerations.

Ms. Bain: But will they be a written part of it?

Ms. Wynne: Will they be written into the legislation—is that what you're asking—or into the agreements?

Ms. Bain: Into the agreements.

Ms. Wynne: I can get that answer for you. I don't actually know. I'll get that for you.

The Chair: You may be able to double-check.

Ms. Martel: do you want to comment on this?

Ms. Martel: Yes, I do. Some of the referral patterns don't make any sense at all. We heard when we were in London that people from Sarnia, who would normally go to London for procedures at the hospital, are now told that their referring hospital is Windsor. So the referral pattern is completely different from the one they had been used to. The minister has said to people that you can still continue to go where you want to. However, we did have a presenter in London raise a scenario to say that she—and we don't know what context it was in because the question and the answer occurred at the end of the presentation. But she did say on the record that she had been told that because she was from Sarnia coming to London, she wouldn't be able to get that treatment because that was not the referral pattern that was envisioned when the LHIN was set up. We didn't get any more information. I can only relate to you what was on the public record.

I do know, though, from people from Kenora that there has been some sense that it's not clear that you can go to Manitoba. For example, your northern health travel grant might be at risk. I know that Howard's office has been getting calls from people who have been told that, albeit we haven't seen an actual piece of correspondence. I have asked Barb in his office, if she gets a piece of correspondence that actually says that, to give it to us because we would raise that immediately as a concern with the ministry. I gather that was something that came out of Closson's report. I don't know all of the details of it, but I can't imagine that the ministry would want to change that at this point, because so many people do go out to Winnipeg.

The Chair: There are two more answers to your questions. First is Ms. Wynne and then Mr. Ramal.

Ms. Wynne: As far as the referral patterns that you're talking about, many of those reside with OHIP and they will continue, they won't be part of the accountability agreements. Everything that will be included in the accountability agreements is still being established at this point.

The issue of—and I'm sorry, I had half an ear listening—whether people can go across LHIN boundaries to get service, absolutely they will be able to do that. The law will not allow people not to go across those LHIN

boundaries. That's absolutely within the purview of the law.

Ms. Bain: I guess I just want to make sure that that's enshrined somewhere.

The Chair: Mr. Ramal, you still had something to add?

Mr. Ramal: No, Ms. Wynne answered.

Mr. Gravelle: Can I say one thing?

The Chair: Yes, Mr. Gravelle, and then I'll go around. Thirty seconds or so, please.

Mr. Gravelle: Just very quickly, I want to make reference to the fact that it would be great if we could be in Kenora. I think I probably speak for Mr. Mauro as well. We're always pleased to have the committee come to the northwest. I've always, for years and years—not just to our government, previous governments—said it would be great to be in Marathon, it would be great to be in Greenstone, it would be great to be in Kenora, it would be great to be in Dryden. We'll keep arguing it would be great to do these things but, quite frankly, it's a challenge. There are so many communities in the province that want to have access to public hearings. I just want you to know I hear you and I've been making that case for some time, but I'm still grateful that we managed to get to Thunder Bay.

Ms. Wynne: Teleconference.

Mr. Gravelle: And the teleconference aspect has been helpful, that's right. Still, in an ideal world, we'd be there.

The Chair: Why don't we have 30 seconds each? Ms. Martel, do you wish to make a statement?

Ms. Martel: Careful, to Mr. Gravelle. I did ask for the committee to go to Sioux Lookout and to Sault Ste. Marie and got voted down. That wouldn't respond to your problem in Kenora, but it might have been a little easier to get to Sioux Lookout versus coming to Kenora. We got some extended hearings but they were not in all the places that I had put forward as an opposition member for us to go to.

Just very quickly, one of your colleagues earlier from Lake of the Woods told us about a situation where Versa foods had run the contract for food and that the board of the hospital had decided after some time it was not very good and the contract wasn't renewed. My concern, of course, is in the legislation. As it currently is written, even if the board says, "We don't want Versa any more, we want it in house," the legislation very clearly says the minister can order that service to be contracted out to a for-profit company like Versa. So that absolutely has to change.

Mr. Ramal: Thank you for your presentation and for your questions. Definitely there are a lot of people we want to hear from and we, as a standing committee—and our party—pushed for seven days instead of four days, for more people and to have more input. Prior to this travel in the province of Ontario, we consulted as a government, the Minister of Health, with 4,000 groups, agencies, individuals and community groups in order to consolidate and come up with suggestions for the bill.

We're going to take your input and that of other people who have been speaking to us for the last four days, and hopefully we can make some kind of changes in order to achieve our goal, which is to consolidate health care in Ontario and have better delivery. As you know, as we speak today, health care in Ontario—yesterday the minister spoke to the London Free Press—is not as good as people think; it needs some kind of reform. That's why we are here.

You started your speech—I call it a speech because I have listened to many of your CUPE locals across Ontario. When they come to us, they come with a political speech, not suggestions. Anyway, that's fine; we'll take it.

I want to tell you something very important. When the Minister of Health was appointed, he had a commitment and a goal to achieve: to fix health care. That's why we got elected in 2003; that's why we are going to do it. Hopefully you will judge us on our results, not just by what you hear, what you have in assumptions and what you are being told. For you and many other people in Ontario, the result is the most important thing.

Mr. Miller: Thank you for your presentation. On that set-up, I guess I'll ask you—the government is heading down the LHIN path, obviously. They've hired the CEOs and a lot of the bureaucracy already and have the boards in place, and the legislation isn't even passed yet. My question would be, will local health integration networks improve our health care system? In the compendium of the bill, it says we're going to have "efficient management of the health system at the local level by local health integration networks." Do you think LHINs are going to improve the health care system, or what direction would you give to the government if they don't improve the health care system?

Ms. Bain: I think everybody who works in health care understands that there's a need for change, but we also think there's a big need for people to listen to us. We're the ones who deliver the care every day, and we don't think we're being listened to. We definitely understand that there has to be accountability, and we see not very good spending, but to move to this system, absolutely not. I think that health care is going to be very threatened. All we see is privatization and having care delivered by people who aren't accountable and maybe not regulated, and that concerns us very much.

The Chair: Thank you very much for your presentation.

THUNDER BAY AND DISTRICT INJURED WORKERS SUPPORT GROUP

The Chair: We are going to hear from Steve Mantis, an addition to the agenda. He is from the Thunder Bay and District Injured Workers Support Group. Please start your presentation. You have a maximum of 15 minutes.

Mr. Steve Mantis: Thank you, Mr. Chairman, and thank you very much for making the opportunity for us to present today. It is very special and unexpected.

We're here, really, as a group of people who receive medical treatment. We don't deliver it. That's not our job, though many of us were hurt in the health care field. We're certainly not experts on this bill, and we're not experts in terms of how the system works or doesn't work, other than from being on the receiving end. You can imagine that we may be one of those groups who are on the receiving end quite a bit.

Of course, if you're injured, you need medical treatment. But research shows that following a permanent injury, a permanent disability—in Ontario there are 300,000 workers today who have a permanent disability, so we're talking about a fair group of people. That group of people tends to have what one researcher called an injury cascading effect. Once you become permanently disabled, you start having a greater risk of reinjury—many of these people are injured a number of times, in the workplace and outside—and overall health issues deteriorate, so people begin to rely more and more on the health care sector.

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So there are a lot of people, and we use the system a lot. We come here, really, as consumers of the system. What we see—mostly we learn a lot about how systems deal with people, a lot of it looking at the compensation system, the Workplace Safety and Insurance Board. That system is structured in a way to look at certain aspects of people's lives: earnings replacement, physical health. The problem is that we're not just physical beings and wage earners; we're people with many different needs and emotions. In order to get people to fully recover, they need to be looked at on a number of levels: certainly the physical, which is most of what our health care is, but certainly on the emotional, mental and spiritual levels.

You guys have a heck of a challenge ahead of you trying to think about how you're going to integrate all these different things into a comprehensive health care system. I'm kind of glad it's not me. I know it's a tough thing.

But within that context, we see changes in our society, and we definitely see a change to more and more privatization on all levels. If you just talk to people in the community—I was talking to a fellow today in one of the government offices as we were waiting in line. We were talking about the roads—the maintenance for all the highways here has now privatized. He said, "You know, I worked for 40 years in construction out on the road, and if I was headed to Ignace," which is three hours west of here, for those who aren't local, "and it was in the middle of a snowstorm, I'd feel secure because the ministry was out on the roads plowing and patrolling. Now we get a few centimetres of snow and the highway is closed because no one is patrolling, no one is plowing regularly."

We start off with privatization saying, "We can save some money." Having worked for a number of years in construction, where you get your jobs by bidding, you get to know some of the tricks. You know how you can bid to meet the minimum requirements of the service, but are you really going to do a good job? If the homeowner, in

my case, doesn't know that six inches of insulation are better than four: "It doesn't matter. I'll just supply the minimum. It's cheaper." But 10 years down the road, you're going to say, "I wish I knew more when I was putting that bid out."

What we've come to see is that relationships that are established long-term are the ones you want to count on. I live outside of town. In our township, it's all done by bid now. It seems like every two or three months we have a new grader operator doing the roads. They don't know the roads. Twenty years ago, we had one guy who did it every year. He knew the roads, he looked after us, he cared, he lived there and he was committed to the environment and the neighbourhood, and we had much better service. The cheaper thing right at the beginning is not always cheapest long-term.

If we look at WSIB, which is beginning to contract out more and more, they've contracted out to private providers the rehabilitation services to help people get back to work. There's no accountability. These people are there and get paid a good buck, but there's no accountability to ensure that the plans they develop really work. So when we look at privatization, we say, "Slow down. The relationships here are more important than the immediate thought of savings."

I want to mention, too, in terms of the selection of the committee—we have these 14 committees or whatever, and the government says that, in the best interests, "We're going to select the best people," and in fact you may select the best people. But when the next government comes along, they get to select and they may not do the same thing. In fact in the last government—I know this personally; my partner has been involved in this area for 25 or 30 years—there was the Early Years initiative in the area of child care. The committee that the Conservatives struck was almost all Conservatives, and they were all mostly interested in making their government look good, not in really looking after kids from zero to six years of age. You may even start with the idea that, "We're going to do the best," but once you put in place a structure, you have to kind of balance it. Someone down the road is also going to have the same choices, and are they going to make the best choices, even if you think you are?

The last thing I want to mention, because I want to leave some time for questions, is that what we think is driving so much of this publicly is the expanding cost of health care. What we see from our members, injured workers, is that a whole lot of costs go into the publicly funded system that maybe should be paid for out of the workers' compensation system, the Workplace Safety and Insurance Board. I'll give you a couple of examples.

A lot of claims go into dispute. If an injured worker is denied entitlement, they may take five or 10 years to resolve that and finally win. All those health care costs for all that time are now billed to the public system. Down the road they realize, "Yes, it was work-related; yes, we're going to give you entitlement," but it is still all paid by the public system. We're saying that if the public

system is underfunded and stressed, maybe we need to look at what some of the root causes are.

Another one we want to mention is the area of occupational disease. We're seeing that up to 40% of cancers may be occupationally related. Those are all covered under the health care system, and we need to look at where those costs are being generated.

I'll stop there.

The Chair: There's about a minute and a half left, 30 seconds each. I will ask Mr. Gravelle to start.

Mr. Gravelle: Thank you very much, Steve. It's good to see you. Your presentation is essentially handwritten; you just got on this afternoon. Are you prepared to put it together in writing? We've been working together on a number of things, but some of these things you and I haven't even discussed. We'd be grateful if you could find the time to put it down in some more formal fashion, and then I can make sure the committee gets it.

Mr. Mantis: As soon as the health care system can do a little cloning, I'm right on it. I'm a volunteer.

The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for making your presentation to us this afternoon. I think you've given us a number of ideas that hadn't been presented to the committee so far today, which will be very helpful as we deliberate on Bill 36. I look forward to reviewing the Hansard of your presentation.

Ms. Martel: Thanks very much for being here today. It's nice to see you again. I'm glad you focused on privatization, because of course there are sections in the bill that facilitate privatization of health care, contrary to what the minister said in his opening remarks and, quite frankly, contrary to the intent and spirit of Bill 8.

Section 33 gives the minister the power to integrate services in hospitals. It says "non-clinical service" right now, but those aren't defined, so what that means is pretty sketchy. But the minister certainly can tell a hospital to outsource its non-clinical services to a "prescribed person or entity." It remains to be seen who that is. It certainly doesn't say "not-for-profit provider or not-for-profit entity." The other place where that continues to concern me is section 25.

Third is the whole area of how the LHINs are going to acquire their services, because of course the legislation is silent on that. Many people have raised concerns that they're going to acquire services in the same way that CCACs do right now, through the competitive bidding model, which has been totally destructive. We have said to the government, "If it's not your intention to have LHINs acquire services through the cutthroat bidding model, then put that in the bill." We'll wait to see if the government does that. Part of the problem around privatization is (a) disruption to the service and (b) the lowering of wages that usually comes, but (c) if you've got limited health care dollars in the system, you want to make sure they go to patient care, not to profits for some of those for-profit providers in the system.

I'm glad you focused on privatization, particularly because there are lots of ways and means it can be done

through this bill, and we wait to see if the government is going to shut down some of those mechanisms that clearly exist right now in the bill.

The Chair: Thank you, gentlemen, for your presentation.

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RÉSEAU FRANCOPHONE DE SANTÉ DU NORD DE L'ONTARIO

The Chair: The next presentation is from the Réseau francophone de santé du Nord de l'Ontario. There are two presenters: Diane Quintas and Diane Breton. Ladies, you have 15 minutes total for your presentation. If there is any time left, we will ask some questions. You can start any time. Bienvenue.

M^{me} Diane Quintas: Merci. Bonjour à tous et à toutes. Merci de nous recevoir pour entendre nos commentaires quant au projet de loi 36.

Mon nom est Diane Quintas. Je suis l'agente de développement pour le Réseau francophone de santé du Nord de l'Ontario pour la région du nord-ouest.

M^{me} Diane Breton: Bonjour. Je m'appelle Diane Breton. Je suis une des membres du conseil d'administration du réseau. En plus, je suis une consultante régionale qui travaille pour l'équipe provinciale des services de santé en français au ministère de la Santé et des Soins de longue durée en Ontario.

M^{me} Quintas: Permettez-moi de vous présenter le Réseau francophone de santé du Nord de l'Ontario. Le réseau a été créé en 2003. Il est un organisme sans but lucratif, géré par un conseil d'administration, composé d'organismes offrant des services de santé, de professionnels de la santé, de membres de la communauté et d'institutions post-secondaires offrant des programmes en santé. Sa mission est d'assurer aux francophones du nord de l'Ontario l'accès à un ensemble de programmes et de services de santé de qualité en français et qui répond à leurs besoins.

Le réseau n'est donc pas un prestataire de services de santé. Son rôle est essentiellement celui d'agent facilitateur, de leadership et d'appui en matière de développement des services de santé en français. Nos activités sont principalement le réseautage et la sensibilisation des intervenants de façon à créer les synergies nécessaires à l'atteinte de notre objectif.

Le territoire que couvre le réseau comprend les districts de Timiskaming, Cochrane, Thunder Bay, Kenora et Rainy River. Ce territoire représente plus de 680 000 km². Pour vous donner une idée, ce territoire est plus grand que celui de la province de Saskatchewan. Selon le recensement de 2001, le territoire couvert par le réseau compte plus de 60 000 francophones, soit près d'une personne sur cinq. Dans le district de Cochrane, les francophones sont même majoritaires.

En général, l'accès à des services en français est déficient dans l'ensemble sur notre territoire. Malgré le fait que plusieurs de nos régions soient désignées par la Loi sur les services en français de 1986, il est pratique-

ment impossible d'avoir accès à l'ensemble des services essentiels en français. Évidemment, le développement des services de santé en français varie considérablement d'un endroit à l'autre. Dans les régions où les proportions de francophones sont les plus élevées, les services de santé en français sont plus nombreux et l'accès est meilleur, mais dans les communautés où les proportions de francophones sont plus petites, l'accès aux services de santé est limité et souvent inexistant. De plus, notre région vit une double problématique. En effet, la pénurie de professionnels de la santé vécue partout dans le nord de l'Ontario se trouve accentuée dans notre région par la nécessité de recruter des professionnels capables d'offrir des services en français et prêts à venir pratiquer dans les régions isolées du nord de la province.

Ce qui est important pour les francophones, c'est de recevoir des services de qualité dans leur langue et qui répondent à leurs besoins afin d'améliorer leur santé et donc celle de l'Ontario en général. Il est clair que pour que les services soient de qualité, il faut que les intervenants en santé et les institutions qui les abritent possèdent ce que l'on nomme la compétence culturelle. Partout dans le monde, il est reconnu que si un système de santé ne possède pas les compétences culturelles pour répondre aux besoins des patients, il est extrêmement difficile de poser un diagnostic de qualité et ainsi intervenir efficacement. La compétence culturelle est donc un déterminant fondamental dans la qualité des soins offerts. Ceci est particulièrement important dans les domaines des soins de santé primaire, du traitement des maladies chroniques et des services entourant la santé mentale. Dans ces domaines, la communication devient essentielle pour les intervenants en santé d'être aptes à proposer des interventions qui sont efficaces et qui donnent les résultats escomptés. De la même façon, on ne peut pas demander à une personne malade de clairement s'exprimer dans une langue qui n'est pas sa langue première. Même dans le meilleur des cas, il est souvent difficile de s'exprimer dans sa propre langue.

La compétence culturelle ne s'arrête pas à la connaissance de la langue mais aussi à la compréhension de la culture des gens que l'on traite ou avec qui on transige. Comprendre la culture, c'est aussi comprendre ce qui nous entoure, ce qui entoure les comportements qui déterminent la santé des populations. C'est de nous permettre d'interpréter ce qui est sous-entendu dans les paroles du patient. Reconnaître la langue sans la culture, c'est se mettre dans une situation où il est beaucoup plus facile de mal interpréter ce que dit l'autre. On pourrait ici donner de nombreux exemples de ces situations, mais là, ce n'est pas notre propos.

Le fait de ne pas posséder les compétences culturelles nécessaires fait en sorte que les services sont de moins bonne qualité, qui ultimement se répercute sur l'état de la santé d'une population. Il est intéressant de noter, à ce sujet, que le deuxième rapport sur la santé des francophones de l'Ontario, publié en décembre 2005, dénote les différences importantes en matière de santé entre les francophones et la majorité. Par exemple, les franco-

phones ont plus tendance à percevoir leur état de santé comme étant moins bon que celui des anglophones. Par ailleurs, les taux de certaines maladies chroniques sont légèrement plus élevés chez les francophones que dans l'ensemble de la population provinciale. On peut également décerner certaines différences dans les comportements de santé des francophones. Comparativement à l'ensemble de la population, les francophones font plus usage des services d'urgence.

Pour améliorer la santé d'une population, il faut donc développer des services qui adressent directement leurs besoins. Afin d'arriver à ce résultat, le projet de loi 36 doit inclure des changements nécessaires. L'établissement des RLISS fait partie de la solution pour les francophones.

M^{me} Breton: Les cinq principes qui guident le mandat et les responsabilités des RLISS sont des principes avec lesquels nous sommes entièrement d'accord.

Le premier : un accès équitable aux soins en fonction des besoins des patients; (2) le respect des choix des patients; (3) des résultats mesurables et tangibles, conformes au libellé de la politique stratégique à la planification des activités et à la gestion de l'information; (4) des services centrés sur le patient, axés sur la collectivité et au diapason des besoins en matière de santé de la population locale; et le dernier, une responsabilité partagée entre les soignants, le gouvernement, la collectivité et les citoyens.

Or, si l'on reprend ces principes sous l'angle de la francophonie : (1) non seulement l'accès équitable est nécessaire, mais l'accès doit être en français, tant au niveau des services directs que des services de soutien des organisations. (2) Le choix des patients, y compris celui de la langue de traitement, doit être respecté. (3) La communauté francophone exige que la loi 36 supporte des résultats à la fois mesurables et tangibles. (4) Pour améliorer les services centrés sur le patient, et au diapason avec les besoins en matière de santé des populations locales, il est nécessaire que les intervenants en santé possèdent les compétences culturelles requises pour desservir la communauté. Il faut donc que des services en français soient mis en place et que les institutions de santé possèdent les compétences culturelles indispensables à l'offre de services de qualité pour les francophones, et ce tant au niveau de la langue que de la culture. Or, la Loi sur les services en français, bien que nécessaire et importante, n'a pas donné les résultats escomptés dans ce domaine. Le dernier : la communauté francophone est prête et souhaite être coresponsable de sa santé et de la gestion des services qui en améliore l'état.

De ces principes, qui sont ceux des RLISS, on peut facilement comprendre ce qui selon nous améliorerait le projet de loi 36.

1510

M^{me} Quintas : Au-delà de la question des droits constitutionnels et légaux des francophones, et ayant fait le tour de la question, il faut maintenant clarifier nos attentes envers le projet de loi 36.

Le réseau ne possède pas les compétences légales pour proposer des changements précis à la loi. Il est clair que

nous souhaitons que les RLISS aient dans leurs responsabilités, d'une façon claire et sans équivoque, la nécessité de desservir la communauté francophone à travers les organismes de santé qu'ils financent. Cette responsabilité doit inclure le maintien et le développement des services en français avec des institutions possédant les compétences culturelles nécessaires pour offrir des services de qualité. Il faut que la loi soit claire et précise à ce sujet.

L'allusion à la Loi sur les services en français dans le préambule est, selon nous, insuffisante. De la responsabilité ajoutée au RLISS découle une obligation d'évaluer les services et ultimement de rendre des comptes à la province et aux communautés francophones. Ce n'est qu'ainsi que nous aurons l'assurance que l'ensemble des institutions et de leurs intervenants sera redevable d'offrir des services de qualité à la communauté francophone.

L'objectif du réseau est de participer à la mise en place d'un système qui donnera un accès équitable à des services de qualité pour les francophones, et nous croyons que les RLISS, établis avec les changements nécessaires dans la loi 36, contribueront significativement à l'atteinte de cet objectif.

Nous sommes heureux que le gouvernement considère la francophonie ontarienne comme un atout, et le Réseau francophone de santé du Nord de l'Ontario est prêt à participer avec tous les intervenants en tant que partenaire afin d'atteindre une meilleure santé pour les francophones de notre région et, par le même fait, pour l'Ontario. Merci.

The Chair: Merci. This is all of the presentation. Monsieur, une minute.

Mr. Arnott: Merci beaucoup. Thank you very much for your presentation this afternoon. We have heard, over the last couple of days, from time to time presentations from organizations representing the views of Franco-Ontarians on this issue. It's my belief that the government is going to want to be listening very carefully to the views you're putting forward to ensure that your constitutional rights are observed and protected as we move forward with Bill 36.

The Chair: Merci. Madame Martel, s'il vous plaît.

M^{me} Martel: Merci d'être venues cet après-midi. Vous avez raison : il y a une petite phrase à propos de la Loi 8 dans le projet de loi, et ça ne sert à rien après.

Hier, à Ottawa, il y avait quelques présentations en français, et nous avons appris qu'il y avait un groupe de travail sur la santé pour les francophones qui avait fait un rapport, et en ce moment ce rapport est aux mains de M. le ministre. Nous n'avons pas vu le rapport et nous ne connaissons pas les recommandations en ce moment. Selon vous—je ne suis pas sûre si vous avez participé à la construction de ce rapport—est-ce que vous pensez que les recommandations qui sont peut-être dans ce rapport vont répondre aux craintes et aux espoirs de la communauté francophone à propos de la santé?

M^{me} Quintas: Nous n'avons pas vu le rapport non plus. Il est encore confidentiel. Nous espérons que oui, en

effet, les recommandations qui vont être mises vont être pour et par les francophones. C'est un groupe de travail de personnes qui oeuvrent depuis bien des années pour améliorer l'accès aux services pour les francophones. En fait, j'imagine que oui, en effet, ce sera le cas, mais je ne peux pas vraiment répondre. Je n'ai pas encore vu le document.

The Chair: Ms. Wynne, s'il vous plaît.

Ms. Wynne: Thank you. I actually just wanted to know whether you were confident in the recommendations of that report. So you haven't seen the report. Just so you know, we are waiting to hear the results and what the reaction to that report will be, and we're confident that the minister is going to take into account the recommendations that were made to him.

Le Président: Merci. Monsieur Ramal.

M. Ramal: Merci pour votre présentation. C'est la même recommandation donnée par l'autre communauté francophone. Je pense que maintenant notre ministre, George Smitherman, travaille avec la communauté francophone et cherche un mécanisme spécial pour aider la communauté francophone de l'Ontario.

The Chair: Merci. Thank you for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3634

The Chair: We'll move to the next presentation, from the Canadian Union of Public Employees, CUPE Local 3634, Kenora, Doug Kurtz and—hello again.

Mr. Doug Kurtz: We travel together.

The Chair: Yes, and that's fine. It's good to see all of you again. Sir, you can proceed any time you're ready.

Mr. Kurtz: Good afternoon. I'm Doug Kurtz. I work as a medical laboratory technologist at the Lake of the Woods District Hospital in Kenora. I am president of the paramedical group, Local 3634 CUPE. I am also co-chair of the Kenora Health Coalition. More importantly, I am a citizen and taxpayer of the province of Ontario.

Like most of the speakers here today, I am not a public speaker, and as you may have noticed, I am quite nervous, but this LHINs legislation to me is so ominous that I am compelled to state my views and not sit back quietly to let it pass without my voice.

Bill 36, or the Local Health System Integration Act, purports to acknowledge that the community's health needs and priorities are best developed by the community health care providers and the people they serve. LHINs purport to localize the provision of health services by enabling local communities to make decisions about their local health system. LHIN 14 starts in the east at Manitouwadge, goes west to the Manitoba border, starts in the south at the Canada-USA border and goes north up to Fort Severn. In an area this large, what is the definition of "local" and what is the definition of "community"? With only nine members being appointed to the LHIN's board of directors, it cannot possibly represent all the communities in LHIN 14.

The LHIN's board is appointed by cabinet. The chair and co-chair are decided by cabinet. Each member continues on the board at the pleasure of cabinet, and as such, can be removed at any time without cause. The LHIN is defined as an agent of the crown and acts on behalf of the crown. The LHIN must enter into an accountability agreement with the ministry, and if an agreement cannot be successfully negotiated, the minister may set the terms of the agreement. The minister controls the funds provided to LHINs on the terms and conditions that the minister considers appropriate. I feel that the LHIN's board will be nothing but a puppet for the government. If they do not follow the government's direction, the strings will be cut and a new puppet will be put in their place.

Under the provincial wait time strategy, the minister is implementing a competitive bidding system for hospital services such as cataracts and hip or knee replacements. I have reason to believe that this will be expanded by the LHINs.

At the town hall meeting that the Kenora Health Coalition organized in Kenora, a speaker said that there was really no change with LHINs, as the minister and cabinets have always had the power over hospital funding and services. My response then was, why are they putting in place a costly new bureaucracy? Are they using the LHINs as a shield against the public outcry that will come when services are cut in that community?

The only way to make the LHINs somewhat local and accountable is to have directors elected or appointed by individual communities to represent them, with the length of the term to be set out in the Legislature. Front-line workers, union and non-union, must also be appointed to subcommittees. If the intention is to allow community health care workers to set needs and priorities, they must be heard.

Another issue I have with the legislation is the amount of job loss that will follow with integration and amalgamation. As a citizen and taxpayer of Ontario, I would expect the government to try to keep jobs in local communities and not attempt to centralize them in another LHIN, as in the case of the NOBOS initiative, or the SOBOS initiative in the south, which is set to go as soon as this legislation is passed. Mr. Smitherman has stated publicly that hospital housekeeping staff get paid too much to push a broom. Is he planning to privatize the service to the lowest bidder? If this is not the case, then it should be put into the legislation that union contracts will be honoured, that legally negotiated contracts will be honoured. With the closing of the paper mill in Kenora, the hospital jobs are all the more important to our community.

1520

In closing, I would like to share with you the most prevalent concern that was expressed to me at the town hall meeting we had about LHINs. The majority of citizens of Kenora just wanted a family physician, a doctor to go to when they were sick instead of tying up the emergency department; a doctor who would renew

their prescriptions and do their medicals. Sad to say, I had to tell them that the legislation does not include doctors and does nothing to address the issue of orphan patients. This legislation is about saving money, not patient care. Our community of Kenora has just bought the medical clinic from the physicians. They feel that if they own the building and maintain the building and just charge rent to doctors, we will actually get a doctor to come to Kenora. That's pretty sad. I can't remember; is it 3,000 orphan patients that we have? That is quite a lot for a community of 10,000. My question is, why is the government not putting money towards buying this complex and trying to entice doctors to serve our community?

Why do I feel so strongly about LHINs? My 80-year-old dad was one of those people in Kenora who had no doctor. He was going to a chiropractor for back pain and the chiropractor suggested that he go to emerg, as it was something far more serious. After a four-hour wait in emerg and X-rays, it was discovered that the prostate cancer had spread to his spine and he was terminal. We were lucky enough to get a doctor to take over his care and monitor him so we could keep him at home until his last days. It was arranged that CCAC would come and do his medicine and arrange for his plan of care. This was in October 2001.

So we had a plan set up. CCAC came in and they were doing his morphine, they were doing his medication. Probably about halfway through it, they came to us and said they no longer could come, that they had gone over their budget and there were other people who needed this care. I do believe that this is the time that they were taken over by the province and they were put out for bid. We were left to take care of my dad, and I have to tell you that I did things to my father that I never thought I would be doing. I was giving him medication that I probably should not have been giving him, and to be in the bathtub with your father naked is not a good way to remember your father. That's probably more information than you want; sorry. In the end, we were forced to bring him to the hospital for the last two weeks of his life because even though there are 10 kids in my family, we could not take care of him around the clock, which was needed.

That said, I will not let this happen to health care. This legislation, the way it stands, opens the door for privatization and centralization. There must be changes and amendments made to this legislation. Amendments have been made by numerous people. As a citizen of Ontario, I'd like these to be looked over and decided on. Thank you.

The Chair: Thank you. We have about four and a half minutes. I'll start with Mr. Ramal at one and a half, please.

Mr. Ramal: Thank you for coming again and presenting before our committee. I guess we agree with you that we have a problem with health care. That's why I want to echo what the minister said yesterday: We are moving toward a system that is more efficient and better able to deliver the kind of health care Ontarians need and deserve. That's why we founded the LHINs. That's why

we're working toward finding a mechanism to communicate with the people of Ontario. That's why we want to break that big, huge silo, huge ministry, humungous ministry, 6,000 people working in Toronto, and divide it into 14 units across the province of Ontario, based locally. Instead of going to Toronto, you go to Thunder Bay, you go to Ottawa, you go to London, etc.: 14 units across Ontario, in constant communication with the local people to have their input and to work with them.

I know from past experience that when the past government was in power and tried to reconstruct health care, what happened? Major layoffs, mayor hospital closures. But the minister said clearly in his opening remarks to this committee, "No hospital closures, no two-tiered health care, medication or hospitalization in Ontario. Yes to publicly funded Ontario health care for everybody, accessible for all." That's our message to you and to all the people in this province from this committee. I strongly support, 100%, publicly funded health care, accessible for all. That's why we got elected in 2003; that's why I'm going to continue advocating on behalf of the people who elected me and on behalf of the people of Ontario.

The Chair: Ms. Wynne, please.

Ms. Wynne: I've heard nothing in this legislation that will allow further privatization or expansion of competitive bidding. Section 33, which has been referred to a number of times, is a transitional section. There is a mechanism within it so that it will be repealed. There are some processes that are under way right now to amalgamate some office services to some hospitals around the province. When those are completed, the intention is that that piece of the legislation will be withdrawn.

I think everything that this minister has done so far since he's been in office has indicated his commitment to publicly funded medicare: Bill 8, the bringing back of private MRIs into the public system and the turning back of the Life Line vans at the border and not allowing them into the province. If actions speak louder than words—and there's nothing in this legislation that would expand privatization—I think we have to understand that that's the intention of the government. There is no secret agenda here.

The Chair: Thank you. Mr. Miller.

Mr. Doug Allan: Can we answer?

The Chair: Well, they made statements. I didn't hear any questions. When he's asked the question, you always have an opportunity to answer.

Interjections.

Interjection: We yield our time.

The Chair: You've got a minute and a half at least to answer.

Mr. Allan: That's interesting information, Ms. Wynne, but what we'd like to know is what services are going to be contracted out before that section 33 is going to be repealed. That would be the key thing. Right now, we've been told that 1,000 jobs will be contracted out, and they're just waiting—just waiting—for this legislation to be passed before 1,000 jobs go out. Services

within that are then going to be privatized. That's what they've told us. We're not making it up; that's what they've told us. This is what Hospital Business Services has told us—HBS, which is funded by the provincial government through Ontario Buys—and it's all been approved by Ontario Buys. The government's seen the same perspective that we've seen that says 1,000—actually, it was a little higher number at that time, but a few hospitals have pulled out; 20% to 25% severance payments are included in their budgets and privatization of services within that. That's pretty major privatization. We know that that's not—

Ms. Wynne: But that's not new authority that this—

Mr. Allan: But section 33 is a new authority. What's more, we're seeing that a lot of the powers that exist that are going to be facilitated by this bill already exist, and we're seeing it right now, as we were saying about the wait time strategies. We're saying stop the contracting out and stop those powers from happening.

Ms. Wynne: I don't think it's my time.

The Chair: No. Mr. Miller.

Mr. Miller: Thank you for your presentation. You said in the middle of your presentation that they have NOBOS and SOBOS ready to go; I think that's what I heard. Could you tell me what that is?

Mr. Kurtz: Northern Ontario back office systems. It's based out of Sudbury, which makes me concerned that maybe LHINs 14 and 13 are going to be amalgamated since Sudbury is actually going to chair this committee for NOBOS. Our CEO just went to a meeting last week in Sudbury about NOBOS.

Ms. Wynne: Would they be collapsed into one LHIN?

Mr. Kurtz: Well, why would you have a NOBOS that took two LHINs in, two separate LHINs?

The Chair: Sir, the floor is for Mr. Miller. He's asking the questions. Can you address him?

Mr. Kurtz: Sorry. I tend to get argumentative. You may have noticed.

The Chair: That's okay. Madam Martel will be next.

Ms. Martel: Thank you for coming back up. Because the Liberals have referenced section 33, I'm going to read it into the record, and you can tell me whether or not it sounds like this section is only for certain processes that are now underway, and once those processes are done, this section is going to be repealed.

Here's what it actually says: "The Lieutenant Governor in Council may, by regulation, order one or more persons or entities that operate a public hospital within the meaning of the Public Hospitals Act and the University of Ottawa Heart Institute ... to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date." And at the bottom, the repeal section, here's how clear it is. "(5) This section is repealed on a day to be named by proclamation of the Lieutenant Governor."

1530

I'm sorry. I don't see any specific reference to processes that are going on right now that, when they're

finished, this section is going to be repealed. I see this as wide open. I don't even know what non-clinical services are, because they're not even defined in the act. So please, do not take any comfort from the minister or some of his folks saying, "This is only for specific processes, and when they're over, this is going to be gone." This is what the legislation says. If the minister or ministry have some other ideas, have something concrete that this has reference to, then put it in the legislation so we can see what it is and we can know when it's going to end.

Secondly, with respect to competitive bidding, you're darn right that's going to lead to increased privatization. If it's not the intent for LHINs to procure services through competitive bidding, then put it in the legislation. It isn't here. If the government means what it says, put it in the bill.

Thirdly, with respect to what the government campaigned on, I remember Dalton McGuinty saying "no private financing of hospital construction." Now we've got at least 16 privately financed hospitals on the go, which are going to cost taxpayers a bundle.

Interjection.

Ms. Martel: Yes, Mr. Ramal, we have quotes from before and after the election to the Ottawa Citizen saying categorically "no private financing of hospitals." That's exactly what your government is doing: private financing of new hospitals, at an enormous cost to the taxpayer.

Finally, with respect to competitive bidding, why do I think it's going to happen? Because the competitive bidding process established by that government in home care has been kept in place by this government. There has been absolutely no change, and the chaos that we saw in home care is going to continue in all other sections that LHINs have responsibility for unless you folks bring in an amendment to say otherwise, and I look forward to seeing you do that.

The Chair: Thank you for your presentation. We went just a few minutes over, but we thank you for your time.

ASSOCIATION DES FRANCOPHONES DU NORD-OUEST DE L'ONTARIO

The Chair: Next are Denyse Culligan and Angèle Brunelle. Their presentation will be in French. You can start any time you're ready, ladies.

M^{me} Denyse Boulanger Culligan: La traduction du document n'est pas prête. Elle va être distribuée lundi au plus tard.

Monsieur le Président, les députés Gravelle et Mauro et chers membres du comité, mon nom est Denyse Boulanger Culligan. Je suis la présidente-directrice générale de l'Association des francophones du Nord-Ouest de l'Ontario. Depuis septembre 2004, je suis membre du Comité consultatif provincial sur les affaires francophones pour la ministre de la Culture et des Affaires francophones. Pendant la dernière année, j'ai siégé comme une des trois représentantes de la ministre

Madeleine Meilleur sur le Groupe de travail provincial sur la réforme du système de santé présidé par M. Gérald Savoie. Le rapport du groupe de travail a été déposé en octobre 2005, et nous attendons impatiemment qu'il soit rendu public. Donc, si vous avez une question à me poser, je ne suis pas vraiment la personne qui peut répondre.

Les Franco-Ontariens et Franco-Ontariennes du nord-ouest de l'Ontario sont minoritaires dans la minorité. Dans le nord-ouest, nous ne parlons pas de la détérioration des services de santé en français, puisqu'ils sont quasi inexistantes. Les droits légaux et constitutionnels de la population francophone n'ont pas encore été respectés après les 20 ans d'existence de la Loi sur les services en français de 1986. Comment pouvez-vous donc expliquer cette situation?

La communauté francophone du nord-ouest de l'Ontario partage les mêmes priorités que le gouvernement ontarien en ce qui a trait à la santé. Nous tenons à ce que l'intérêt public soit respecté; les francophones reçoivent des services de santé de qualité ponctuels en français; la santé de notre population s'améliore; et que les fournisseurs de services soient redevables. L'intérêt public implique le respect du principe fondamental du respect et de la protection des minorités linguistiques. La Loi 36 devrait le spécifier.

S'ajoute à tout ceci la protection des droits constitutionnels des Franco-Ontariens reconnus par plusieurs jugements de la Cour suprême et dans le jugement Montfort de la Cour d'appel de l'Ontario. Il est souvent dit d'un pays qu'il sera jugé par la façon dont il traite ses minorités. Le jugement serait très sévère envers l'Ontario si on devait le fonder sur la façon de laquelle notre province traite la minorité franco-ontarienne du nord-ouest. Nous sommes des laissés-pour-compte et perçus comme des citoyens de deuxième classe. Pourtant, nous sommes un peuple fondateur du Canada.

Ce n'est pas seulement une question de droits. L'absence de services de santé en français n'est pas la meilleure pratique et occasionne des délais, des diagnostics plus difficiles, des lits occupés plus longtemps, des patients plus vulnérables et malades, et engorge tout le système de santé. Un service de qualité en anglais, offert à une personne d'expression française, peut facilement devenir un service médiocre, pour ne pas dire dangereux, qui affecte non seulement la qualité du service de santé mais la qualité de vie du patient. Quand il s'agit de services de santé, l'importance de l'utilisation de sa langue de la part du patient et la compréhension de la culture de la part du fournisseur sont des éléments clés à la prestation de services qui répondent au besoin imminent et permettent l'efficacité et la ponctualité du traitement.

Je vais laisser la parole à M^{me} Angèle Brunelle, qui va se présenter. Elle va vous donner quelques exemples de ceci.

M^{me} Angèle Brunelle: Bonjour. Mon nom est Angèle Brunelle. Je suis directrice générale de l'Accueil francophone de Thunder Bay.

J'aimerais partager avec vous deux situations qui illustrent clairement comment l'incapacité de communiquer dans sa langue maternelle peut avoir des conséquences désastreuses.

Le premier exemple est celui d'un homme professionnel, unilingue francophone, d'environ 35 ans. En mai 1991, cet homme a subi un malaise et s'est rendu à l'hôpital de sa communauté. Le médecin, soupçonnant un infarctus du myocarde, l'a transféré aussitôt par hélicoptère à l'hôpital régional. Le spécialiste a administré au patient une batterie de tests.

Le lendemain, constatant que l'état du patient s'était amélioré, le médecin l'a renvoyé chez lui. L'homme croyait profondément qu'il avait subi une crise cardiaque. Cette conviction a eu plusieurs effets sur sa vie. Par exemple, à cause de son état de santé, il a eu de la difficulté à obtenir une hypothèque, ainsi qu'une assurance-vie.

Quatre ans plus tard, un médecin bilingue est venu s'installer dans sa communauté. Lors de sa première consultation, l'homme a informé le médecin de sa condition. Le médecin, prenant connaissance du dossier médical, a avisé l'homme qu'il n'avait jamais fait de crise cardiaque et que le problème en question n'était en fait qu'un ulcère à l'estomac. Quatre ans de stress pour lui et sa famille parce que personne ne pouvait lui parler en français; serait-ce acceptable pour un membre de la majorité?

Le deuxième cas dont j'aimerais vous parler est beaucoup plus tragique. Il s'agit d'un homme dans la quarantaine, ayant une connaissance limitée de l'anglais, qui a été admis à l'hôpital à cause d'un caillot sanguin à la jambe. Le patient a été informé qu'il devrait subir une chirurgie pour régler son problème. Il a signé le formulaire de consentement en pensant que le chirurgien enlèverait le caillot sanguin. Lorsque l'homme s'est réveillé après l'intervention, il s'est rendu compte qu'on lui avait amputé la jambe. Cet homme n'a pas eu l'occasion de prendre une décision éclairée, ni de s'adapter graduellement à sa condition.

Imaginez-vous simplement l'horreur de vous réveiller dans un lit d'hôpital avec un membre en moins. Vous n'étiez pourtant pas inconscient lorsqu'on vous a fait signer une formule de consentement. Votre seul défaut est de ne pas parler l'anglais.

M^{me} Boulanger Culligan: Comme vous voyez, ces deux situations auraient été traitées différemment si seulement les patients avaient pu communiquer avec des professionnels de la santé dans leur langue maternelle.

L'Association des francophones du Nord-Ouest de l'Ontario, avec ses 23 groupes membres et ses partenaires, travaille constamment pour contrer l'assimilation, empêcher l'exode de notre population, promouvoir une population et des communautés en santé, et revendiquer nos droits à une pleine participation dans la société ontarienne. L'utilisation de la langue française est implicite à cette participation. Notre diversité culturelle est une valeur ajoutée à la société. Malheureusement, l'attitude de la majorité envers notre histoire et nos droits se situe souvent entre l'ignorance et l'apathie. Nos droits

ne sont pas respectés par le simple fait que plusieurs d'entre nous pouvons nous exprimer dans une langue autre que la nôtre, et on nous reproche de vouloir utiliser notre langue maternelle. Cette excuse n'est pas valable, et encore une fois ne respecte pas nos droits.

1540

La transformation du système de santé proposée par le ministre nous est acceptable seulement si elle reconnaît que les décisions touchant les services en français sont prises par les francophones. La majorité a déjà fait la preuve que les décisions qu'elle prend en ce qui touche le développement de services de santé en français sont inadéquates. Il est grand temps que les déficiences du système soient rectifiées. Les difficultés que les Franco-Ontariens vivant en région géographiquement éloignée et en situation linguistique minoritaire ne sont pas insurmontables. Par contre, une volonté politique et une reconnaissance de l'esprit de la loi par le gouvernement et les institutions ne sont pas suffisantes pour répondre aux obligations constitutionnelles et légales majeures de l'Ontario envers la minorité francophone.

Nous sommes encouragés par la reconnaissance dans le préambule de la Loi 36 proposée du respect de la diversité et du respect de la Loi sur les services en français. Cependant, nous nous demandons pourquoi cette loi ne reconnaît pas le rôle de la communauté francophone, un peuple fondateur de notre pays, dans les décisions touchant les services de santé. La Loi 36 doit utiliser un langage clair qui protège suffisamment la participation active et permanente de la communauté francophone à la gouvernance qui dirige le développement, la planification et le maintien de services de santé de qualité en français.

Également, la reddition de compte doit être l'objet d'une attention particulière. Pour nous, la priorité est le développement de soins primaires en français. Ensuite viennent les services hospitaliers où il est inacceptable de ne pas avoir de personnel et de services bilingues. La situation des francophones dans le nord-ouest demande une collaboration avec les institutions de soins de santé à tous les niveaux et oblige que des indicateurs de rendement précis soient établis pour toutes les institutions où nous devons aller chercher nos services de santé.

Il est aussi primordial pour nous que la loi stipule que l'accès aux services de santé en français auquel nous avons droit soit assujéti à un système d'évaluation qui permettra autant la planification de l'amélioration des services par les francophones que l'imputabilité des institutions.

Soyez assurés que les francophones du nord-ouest sont d'accord avec les propositions d'amendements qui vous seront présentées sous peu et que nous sommes solidaires avec les recommandations soumises au ministre Smitherman par le groupe de travail Savoie. Merci.

The Chair: Thank you. Merci. We have about three minutes and we'll start with Mr. Arnott. One minute each, please.

M. Arnott: Merci beaucoup. Votre présentation est très intéressante, et nous écoutons votre idée.

Thank you very much for your presentation. That's the best I can do in French. I want you to know I believe that this committee is listening carefully to the views that are being put forward by Franco-Ontarians with respect to Bill 36, and I would hope that there's a desire on the part of the government members to take that message back to ensure that there are amendments to ensure that Franco-Ontarians receive the health care they are entitled to in their own language. So thank you very much for being a part of this process.

M^{me} Martel: Merci pour votre présentation cet après-midi, toutes les deux.

Vous étiez représentante sur le fameux comité. Je pense que vous avez travaillé si fort. Je pense aussi qu'il vous est interdit de parler à propos des recommandations. Mais est-ce que vous pouvez nous dire, si les recommandations sont acceptées par le gouvernement, est-ce que les craintes dont vous avez parlé dans cette présentation vont être réduites à propos du projet de loi? Il est bien clair que le projet de loi 36 parle seulement à propos du projet de loi, sans détails à propos de comment on peut protéger et aussi améliorer les soins de santé de qualité pour les Franco-Ontariens. Alors, avec les recommandations, est-ce qu'on peut avoir une amélioration dans la situation pour les Franco-Ontariens?

M^{me} Boulanger Culligan: Absolument. Nous avons formulé les recommandations exactement pour aider non seulement la population franco-ontarienne mais aussi le gouvernement à remplir leurs responsabilités constitutionnelles et légales envers notre population. Donc, oui, les recommandations sont très fortes et vont améliorer et être ancrées dans la loi si le gouvernement accepte les choses qui sont nécessaires.

M^{me} Martel: Deuxième question : je ne suis pas sûre à propos du nombre de recommandations—

M^{me} Boulanger Culligan: Il y en a cinq.

M^{me} Martel: Si le gouvernement met en place seulement une ou deux de ces recommandations, est-ce qu'on pourra vraiment avoir une amélioration de la situation, à votre avis?

M^{me} Boulanger Culligan: Ça dépend desquelles.

M^{me} Martel: Desquelles? Bon.

M^{me} Boulanger Culligan: Il y en a une ou deux qui régleraient les vrais problèmes.

The Chair: Thank you.

M. Ramal: Merci pour votre présentation, et merci pour vos pensées sur la transformation du système de santé proposée par le ministre, bien pour la communauté entière de l'Ontario, sauf pour les services en français. J'ai une question pour vous. Quelle recommandation pour la communauté peut améliorer la Loi 36?

M^{me} Boulanger Culligan: Est-ce que vous parlez des recommandations formelles qui ont été faites dans le rapport?

M. Ramal: Oui.

M^{me} Boulanger Culligan: Non, c'est confidentiel. Je ne peux pas les partager avec vous, et le gouvernement n'a pas encore rendu le document public. Donc, il faut attendre que le ministre fasse l'annonce.

M. Ramal: Si beaucoup de gens viennent parler avec nous des recommandations, pour que notre comité puisse comprendre, qu'est-ce que vous pouvez recommander pour le ministre et le ministère?

M^{me} Boulanger Culligan: Nous, on fait des suggestions. Ils vont avoir des amendements, des recommandations d'amendements, précis qui vont être présentés par l'alliance des réseaux. Je pense que c'est le 8 février. Donc, nous sommes d'accord avec les recommandations qui vont être présentées à ce moment-là, et j'attends qu'eux les partagent avec vous.

M. Ramal: Merci.

The Chair: Thank you, ladies, again.

KENORA CHIEFS ADVISORY

The Chair: The next presentation is from the Kenora Chiefs Advisory, Tania Cameron. Whenever you're ready.

Mr. Ramal, would you like to take the chair for a few moments, please?

Ms Tania Cameron: Good afternoon. My name is Tania Cameron. I'm with the Kenora Chiefs Advisory. I guess I want to start by introducing the Kenora Chiefs Advisory. We represent seven First Nations within the Kenora area. They are Wabaseemoong, Grassy Narrows, Ochiichagwe'Babigo'ining, Obashkaandagaang, Naotkamegwanning, Shoal Lake 39 and Shoal Lake 40. Within the Kenora Chiefs Advisory, we deliver health and social services, both federal and provincial programs.

I'd like to mention that in the spring of 2005, the province of Ontario announced an action plan, a new approach to aboriginal affairs. In it, the McGuinty government promised respectful relations with First Nations and aboriginal service providers. As well, the document stated, "Aboriginal people will have greater involvement in matters that directly affect their communities, including, where applicable, in programs and service delivery."

I guess that sort of leads off to where the Kenora Chiefs Advisory takes issue: that we weren't consulted in the beginning. We understand that there were workshops in November, December and then in January 2005 talking about the LHIN. We asked the First Nations if they received any of these invitations. They didn't. We do our best, if we receive these invitations, to forward them to our communities, and we've heard the tail end. We learned later that in LHIN 14, aboriginal issues were 11th on the list. It didn't even make the top 10 priorities. Given that within the LHIN 14 geographical scope there are a quite a number of First Nations, that was a huge concern to us.

1550

Our leadership, through the Chiefs of Ontario, held a meeting with Minister Smitherman in May 2005 shortly after this promise was announced to Ontario. We had concerns over the non-participation of First Nations people regarding this change and the new structure of the LHIN. This meeting was held. Our chiefs had requested

LHIN 15, an aboriginal-specific LHIN, and that was immediately denied. What was offered was the task force and some dollars attached to it. The Chiefs of Ontario did agree with this, so the First Nations task force on the local health integration network was struck. I have sat as the technical rep for our Treaty 3 territory. Our objective was to identify potential impacts of LHINs on First Nations health and services. Our final report was submitted in December 2005.

What I wanted to mention is that, from the beginning, there were barriers. The first barrier I mentioned was that in LHIN 14, aboriginal issues did not make the top 10. Another one was that immediately, at our first task force meetings, we requested a number of documents from the health results team, one being the document on the need to integrate health so we can better understand where the integration was coming from. We requested a memorandum of understanding. We requested bylaws of initial LHINs. We also requested the training, design and orientation package for the LHIN board and staff to see if there was any aboriginal-specific orientation that was taking place. We never received those documents, and we had made numerous requests.

In August, we had asked Minister Smitherman eight specific questions that we felt we needed to know in order to address these potential impacts. We asked that in mid-August and we got it at the end of November. Our task force was mandated to serve until November 15, so that was very frustrating.

We asked right from the beginning to review draft legislation to clearly identify potential impacts of LHINs on First Nations and aboriginal organizations. Like I said, it was asked a number of times and, finally, late on November 2, we were told that we could get a PowerPoint presentation of this draft legislation, but we had to be there for November 4 for this meeting at 8:30 to 9:30 in the morning in downtown Toronto. Even just myself, with family commitments, work commitments, to ask me to go from Kenora all the way down to Toronto the next day to listen to an hour presentation, I couldn't do it. So I requested a teleconference and the PowerPoint presentation forwarded to me. Technical difficulties did not allow me—not on our end, on their end. We couldn't get the PowerPoint presentation, and we were told that it would be a one-way dialogue, so we couldn't ask questions. It was very frustrating and I thought it was a waste of time.

Like I said, we had the first meeting of our task force in July and they wanted a report by November 15. Of course, we were late because we didn't get a lot of the documents we'd requested, and when we did, it was within the last two weeks of the task force mandate. I wanted to state those frustrations with that.

In the short time, we met every day, through e-mail and teleconferencing, as a task force to try to come up with our recommendations towards the legislation. I brought this to our chiefs, who are the board of directors for the Kenora Chiefs Advisory. I brought it to the health directors in the First Nations, and this is the best we can do, I believe.

One, we wanted to address the governance and accountability. It is a priority that the LHINs identify First Nation citizens on and off reserve. The province must respect their legal obligations and co-operate with First Nation governments. The ministry should be dialoguing with all PTO representatives to define First Nation service providers on and off First Nation communities.

To ensure effective accountability, we recommend a minimum of one aboriginal seat on the LHIN board. Further to that, for the LHIN 14 board, we're hoping for at least two aboriginal seats on this LHIN. I know it's already been selected, but this is our recommendation.

Since there is a legal obligation to consult, and in this situation it was ignored, the province must fulfill its duty to consult in a government-to-government process.

The other one we identified was recommendations towards health system planning and evaluation. For the LHIN to be accountable to First Nations on- and off-reserve, there must be co-operation with First Nation governments to identify gaps and priorities by consultation and examination of existing structures.

An evaluation process needs to be undertaken in partnership with First Nation governments to safeguard against the closing or dismantling of services. This would also help determine the viability and success of programs, based on needs and evidence.

First Nations have the right to decide our own health criteria and needs. This may result in a First Nation performance management process being established.

The other one was service delivery coordination and integration. Services and programs must be developed by First Nations both on- and off-reserve which include planning, implementation and evaluation. This could be accomplished through consulting with local health planning authorities.

The human resources and staffing component: The province must be prepared to meet the human resource challenges in First Nation communities.

Ministry of Health and LHIN staff should also have specific training in aboriginal health and social issues. This is, again, what the task force had wished to identify.

Another one was the northern issues. LHIN 14 is not sufficient to meet the needs of such a vast geographical area. It is the largest area in Ontario. We recommend at least—I believe that was—two aboriginal seats on the LHIN, one of course from the Treaty 3 area and one from the other aboriginal PTO within LHIN 14.

Role of Health Canada: We wanted to make sure we stated this, especially in light of the Blueprint on Aboriginal Health. The Kenora Chiefs Advisory advises that Health Canada maintain fiduciary responsibility and that the federal government must be accountable to First Nations in the provision of services, regardless of collaboration with the provincial government. The best possibility is to use the intergovernmental process to bring the federal government to the table to negotiate with First Nations, the province and the LHINs. This must be a coordinated approach.

Community engagement: There must be engagement of individual First Nation communities on and off reserves, given the fact that each First Nations' rights and interests are unique. Joint decision processes must be developed and implemented to ensure that communications continue on an ongoing basis to fulfill the duty to consult.

The community engagement is very important. A lot of our First Nations didn't know that LHINs were happening, in the middle of LHINs being announced. So the task force prepared a fact sheet that was circulated to each of the First Nations on how we understood the LHIN to be going, LHIN expectations and First Nation participation in any of the workshops being held.

We of course recommend that LHIN 14 make effort to communicate with each of the First Nations in its area, to share information, and to just have continual dialogue.

One area that I had been concerned with is that the LHIN is already in place; the district health councils are out. The first funding announcement that I've seen was made, I believe, in July 2005 for home care and CCACs. I did the math: Across Ontario, 3.8% of these dollars went to First Nations and aboriginal organizations in Ontario. That, to me, is an indication of future funding announcements for other provincial programs, and it worries me.

That's all I had to present.

1600

The Vice-Chair (Mr. Khalil Ramal): Thank you, Tania, for your presentation. We have about a couple of minutes left. We can divide it among the three parties. First, Ms. Wynne.

Ms. Wynne: Thank you very much. Thanks for being here. Thanks for taking part in the process. I understand your point of view in terms of there having been barriers, and I think some of the language that's been used here is—going forward, it's certainly our hope that the recommendations that came out of that task force report will inform the final legislation. I mean, we can go back and forth about how many meetings there were, and whether it was enough or not. If the sense is that it wasn't enough, then my hope is that, going forward, we'll be able to take your concerns into account.

Ms. Cameron: It wasn't the number of meetings. It was the information that we weren't able to get, and that was very frustrating—to try to identify impacts for our people when we didn't have the information in front of us.

Ms. Wynne: I think for everybody involved in this process right now, it is an evolutionary one. We're trying to put in place a framework that's going to allow communities to figure out what the gaps are and coordinate the providers in their communities. I know communities are larger and smaller, depending on what part of the province we're talking about, but that's the evolutionary process, and it really is our sincere intention that those decisions be made at the local level in order to meet the needs of people and to deal with regional disparity. That's what we'll be trying to do at every step of the way.

Mr. Miller: Thank you, Tania, for your presentation. Often, it seems with First Nations their issues get lost among the various levels of government, as demonstrated this fall with the Kashechewan water crisis, when the provincial government didn't even realize they had a signed agreement with the federal government that made them responsible for declaring an emergency and evacuating people. That's in other issues, not necessarily health issues, but from my own riding I've seen that, where you can't get any solution to a simple problem because it's always complicated between the three levels of government. So I guess my question is, what advice do you have, with that in mind, to make sure that the First Nations' health issues don't fall through the cracks in this LHIN process?

Ms. Cameron: I guess that would be the promise in the document, Ontario's New Approach to Aboriginal Affairs. They sound like really good words. Let's use them. Just dialoguing with us, taking the time to say: "Okay. What are the aboriginal priorities? What are the aboriginal issues? How can we address them? How can we work with you?" That's pretty simple, but—

Mr. Miller: You need the federal government there too, because—

Ms. Cameron: And that's where I mentioned the Blueprint on Aboriginal Health.

Ms. Martel: Thank you for making the presentation today. I have a comment and then a question. I guess we all hope that things go better moving forward, but I think it goes without saying that it was a pretty poor start to a government-to-government process, especially when it followed on the heels of the government announcement that there was going to be a new relationship with aboriginal people. The first process out of the gate wasn't a very pleasant one and certainly wasn't a good way to start. I hope this is not going to be the pattern that we see then with other ministries. So let me just say that.

Secondly, would it be the position of the chiefs in Treaty 3 or of the Kenora Chiefs Advisory that the way to handle the situation now would be that a clause with respect to non-derogation be included in the legislation and, perhaps further, a clause that makes it very clear that on-reserve First Nations are exempt from Bill 36?

Ms. Cameron: I'm not sure how that would—I know the Chiefs of Ontario are going to be delivering a clear presentation. They're talking about exemption. They're talking about the non-derogation clause.

Ms. Martel: So we should look for that in their presentation in Toronto next week.

Ms. Cameron: Oh, definitely. I don't want to presume to speak on behalf of them. So I'll leave it to Angus Toulouse.

The Vice-Chair: Thank you very much for your presentation.

CANADIAN UNION OF PUBLIC
EMPLOYEES, LOCAL 4807

The Vice-Chair: Now we have the Canadian Union of Public Employees, Local 4807, Riverside Health Care

Facilities Inc.: Corinne Webb, president. Go ahead. You have 15 minutes for your presentation; you can start at any time.

Ms. Corinne Webb: Good afternoon. My name is Corinne Webb and I'm the president of CUPE Local 4807 at Riverside Health Care Facilities. I'm a health information management professional, I belong to the Canadian Health Information Management Association and I'm responsible for coding and abstracting of all medical records for data submission to CIHI, transcription of medical reports, and privacy and release of medical information. As the president of my local, I represent 230 hospital workers in Fort Frances, Emo and Rainy River, Ontario, communities that border the province of Manitoba and the United States. We are as far west as you can get in the province of Ontario.

Riverside operates one 60-bed medical surgical community hospital in Fort Frances and two small rural hospitals in Emo and Rainy River, 15 and 24 primarily long-term care beds respectively, serving a population of approximately 20,000 and employing over 400 personnel. Some of those personnel I represent include clerical, dietary staff, housekeeping staff, pharmacy technicians, health information management professionals, materials management staff, RPNs, paramedics and maintenance and trades.

A brief overview of the services we provide at Riverside, or just what goes on there: Our patients requiring tertiary care are transferred primarily to Manitoba for cardiac, urological and vascular services, as nine times out of 10 there are no beds available in the Thunder Bay hospital. We're smack dab in the middle of Thunder Bay and Winnipeg, four hours each way. Our patients are also sent across the US border for urgent CT scans. As Sister Judy Bain pointed out, I'm concerned that the legislation will change referral patterns and the ability of these patients to receive CT scans as quickly as they do now.

Our hospitals in Emo and Rainy River are primarily long-term care, allowing these patients to stay close to home. We have visiting specialist clinics in the Fort Frances hospital offering services in cancer care, orthopaedics, paediatrics, rehab services and orthotics. We have renal dialysis on-site in Fort Frances, we have mental health counselling in all facilities and we also have chemotherapy for cancer patients.

The members of my local, as well as those of the local representing our home for the aged, and community support and members of ONA are genuinely concerned with Bill 36, the Local Health Services Integration Act, and the effect it will have on how health care services are restructured.

The North West LHIN, LHIN 14, which we belong to, covers a huge geographic area, approximately 560,000 square kilometres, from the Manitoba border north to Hudson's Bay and east to Manitowadge. The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation—what services a LHIN will provide in each area of the LHIN. Unlike the government, the LHINs will not

be able to increase revenue. Smaller communities, like ours, may be the first to see their services integrated into other communities.

Bill 36 paves the way for the government to restructure public health care organizations any way it chooses. Firstly, the LHINs have funding powers to facilitate consolidation. They also have accountability agreements with health service providers. You would think these tools would be sufficient for the government to restructure public health care; however, even more authority has been given to the LHINs, the minister and cabinet to force consolidation.

LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service, or to transfer a service. The bill gives the minister even more powers to order integrations directly. The minister may order a not-for-profit health service provider to cease operating, amalgamate or transfer all of its operations. For-profit providers are exempt from this threat.

The bill allows cabinet to order any public hospital to cease performing any non-clinical service and to transfer it to another organization. This means that the government can centrally dictate how all non-clinical services are to be provided by hospitals, including through privatization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of a non-clinical service, so this definition may be a matter of considerable controversy.

1610

If I could just take a moment here to ask a question of the panel: Can anyone tell me why the cabinet needs the power to contract out support jobs like mine over the objections of my hospital?

The Vice-Chair: Do you want to direct your question to somebody specific?

Ms. Webb: No one specific.

Ms. Wynne: The cabinet is not going to do that without the recommendation of the LHIN. I guess if you want to have a conversation about the history or contracting out of ancillary services, we can do that, because that practice hasn't begun with us. Maybe you want to wait until the end of your presentation?

Ms. Webb: Okay.

The government refers to this restructuring as integration, stating that the goal is the creation of seamless care and a true health care system. This is misleading: The LHINs restructuring will not unite hospitals, homes, doctors, laboratories, home care providers and clinics. The LHINs will set a price for services and then tender for them, awarding the contract to the lowest bidder. The LHINs purchaser-provider model will increase competition between providers.

There are no provisions in the bill which guarantee preservation of the public, not-for-profit character of our health care system. The government would now be armed with the legal authority to privatize large parts of our publicly delivered health care system. The LHINs will

purchase services from the hospitals, homes and community agencies, and for-profit agencies will provide them. It's the same model that destroyed community-based, non-profit home care in Ontario, diminishing the continuity and quality of care provided to patients. Home care workers lost their jobs as providers lost contracts, or they left the sector because of low wages, few benefits and no job security.

The government plan is to regionalize hospital support services. With government support, dozens of hospitals across the north are planning to consolidate supply chains and office services by turning work over to the new employer, Northern Ontario Hospital Business Services, or NOHBOS. This is a major change that may have far-ranging consequences for workers and local communities.

An exclusive focus on support services wouldn't satisfy the cost savings demanded by the government. These savings will also require clinical cuts, i.e., the centralization of hospital surgeries. This raises the prospect of even more travel to multiple sites for health care services.

The government has started to move surgeries right out of hospitals and place them in clinics. The creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to as they tend to their health care needs. It also raises the possibility of the establishment of for-profit surgical clinics.

Wouldn't it make sense for the government to create surgical clinics in the facilities and organizations in which we are already invested? Hospitals have the infrastructure needed to support these surgical clinics. There's no need to duplicate human resources, stores, payroll, purchasing, cleaning, food, lab and other support services. Hospitals also have the resources to deal with any emergencies that may arise during operations, and this would actually help advance the seamless care this reform is supposed to create.

Like so much restructuring, these moves will have a major negative impact on hospital support workers. This certainly will not create seamless care for patients. Instead, they create more employers and bring in more for-profit corporations into health care.

Integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reductions in community control and provincial government accountability make it easier for the government to implement these threats. We need a fundamental change.

The change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. Health care and social service workers have been through many rounds of restructuring already, and we were always assured the various changes were for the best. Too much of this restructuring simply consumed enormous energy and resources, exhausting

health care and social service workers, yet we face change on an even broader scale now.

My members have been through cutbacks and layoffs over the years. Our hospital is one of the largest employers in the area. Where are my people to go if they lose their jobs? Transfer to employers in a different community is not an option for many people. These local communities can be hours away—away from the families and friends we've chosen to stay close to. What of technical-professional members like myself, a health information management professional with 20 years of service and seniority? No one else in my community is in need of my qualifications. Where will I go if the LHIN decides to move health record services to another employer in another community? I made a choice to stay in my community, close to my family, and to pursue this career because the hospital would always be there. But this reform might change all that.

CUPE is not convinced that the government fully recognizes the implications of this legislation. As workers faced with this change, we deserve, at a minimum, a fair process that will provide reasonable employment security and protect working conditions, collective agreements and bargaining unit rights.

CUPE is closely examining the impact that Bill 36 and its use in some cases of the Public Sector Labour Relations Transition Act to deal with labour relation issues raised. We are concerned that the Public Sector Labour Relations Transition Act may not be applicable in cases where the entity receiving the work is not a health service provider and where the primary function of that entity is not the provision of services within the health sector. This may allow the LHINs or the government to transfer work without providing health care workers the right to a union representation vote. We would also like to make it crystal-clear that this bill cannot override employment security protections in our collective agreements.

Some of my personal concerns about Bill 36:

- loss of care close to home for the residents of small communities, resulting in hardships to families and requiring travel in often undesirable conditions;

- decrease in level of health service provided due to a competitive bidding model and lack of preservation of a public, not-for-profit health care system;

- loss of job security for health care workers, both unionized and non-unionized;

- loss of support in non-clinical services or having these services contracted out to for-profit corporations; and

- creation of another level of bureaucracy to fight through for local health care issues.

For these reasons, I believe this bill and the government's attempt to restructure health care need to be rethought. I urge the government to take a considered and consultative approach. Consult with the local communities and health care workers and the public about how health care should be reformed.

Mr. Allan: If I can just add, to follow on Ms. Wynne's comments, which I appreciate: It is true that we

have dealt from time to time with a desire by hospitals to contract out services, but what is new, what the government intends to do, is these new powers around Bill 36 which create a potential for contracting out on a much broader scale and with a level of government that we have a very difficult time dealing with.

We feel that we create very often with our employers a recognition that the work is done best in-house and that they feel very comfortable with that. In many cases, such as in this hospital, there is a very long tradition of keeping that work in-house, and that's a very warm feeling that exists and has been around for years. There's no question about that. But now these very hospitals are threatened with powers they can't control, for which that work could be contracted out, and we're now facing that, as I say, throughout the province. In many support areas, this is what we're looking at.

The Chair: Thank you very much for your presentation. There's no time for questions. Thank you.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0N

The Chair: The next presentation is from the Service Employees International Union, Local 1.0n. Is Barb Rankin present? Good afternoon. We did hear a presentation from another member of your group yesterday, I think. There's a total of 15 minutes. Please start whenever you're ready. Thank you.

Mr. Jeff Rooney: Good afternoon. My name is Jeff Rooney. I'm a union representative with the Service Employees International Union, Local 1.0n, and with me today is Barbara Rankin, also a union representative with SEIU. Through our Thunder Bay office, we both service a wide array of health care members, which cover through northwestern Ontario, and we'll be sharing today's presentation.

SEIU Local 1 represents 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services across Ontario.

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We've heard complaints about the rising compensation and salary costs of health care budgets from the previous government. Mr. Smitherman has also recently alluded to the same fact. Let's face it: We're dealing with a service-oriented sector, which invariably involves people. It's not abnormal to spend 80% of the budget on human resources. Our members in the hospital setting earn approximately \$33,000 to \$35,000 per year. Our members working as personal support workers in home care average approximately \$26,000, which is exceedingly close to the poverty line. Can we refer to these salaries as being excessive? I think not, particularly not if we compare these salaries to some of the CEOs of these hospitals, who may earn in excess of \$700,000 per year.

The previous government's attempts at containing health care costs resulted in the implementation of the health tax, whereby health care workers, our members, are now subsidizing their own wages up to \$900 per year.

If you want to contain costs or trim fat, don't take blood from a stone. Our members or the front-line workers are not the cause for rising health care costs.

The Honourable George Smitherman, in a speech to the standing committee on Bill 36 on January 30, 2006, stated, "Reshaping, fundamentally changing, improving: That's what we set out to do with Ontario's health care system with this bill."

It wasn't difficult to conclude, after reading the bill and with the interpretive assistance of several lawyers, that Bill 36 definitely was "reshaping" and "fundamentally changing" Ontario's health care system, the negative effects of which are only as limited as the creator's imagination. What we don't understand is how these changes are going to improve the current health care system.

One of the best strategies to combat your opposition is to beat them to the punch; in other words, prepare your audience for what to expect while defending your own position at the same time. That is exactly what Mr. Smitherman did when addressing the standing committee. After forewarning the standing committee on what to expect throughout these presentations regarding Bill 36, Mr. Smitherman urges you to ask the following questions: "Where does the bill do that? Where in the bill does it say that?"

We suspect that this committee has the foresight and aptitude to deflect the rubbish which Mr. Smitherman has delivered. Weasel words won't confuse the educated. Remember, Bill 36 has been carefully and cleverly crafted, and we're not surprised that the bill doesn't specifically say, and I'm going to quote, "Local health integration networks are going to extend the competitive bidding model to the entire public health care system." We're not surprised that it doesn't specifically say, "Local health integration networks will result in patients having to travel further" distances for health care, or that it doesn't say, "Local health integration networks will mean lost jobs and lower wages," or even "Local health integration networks are not going to close hospitals."

The bill, as written, provides the ability or has the desired momentum for these outcomes to flourish. That's the problem. It's also what the bill doesn't say that scares us and those who are aware of this bill.

In determining whether the bill provides the opportunity or has the effect for these devastating changes to occur, we urge you to ask yourself the more appropriate question, "Does the bill prevent these situations from occurring?" The answer to that question simply is no.

In Smitherman's speech, on more than half a dozen occasions, he referred to decisions being made by people closer to the action. Although we are hopeful that the composition of the LHINs will be comprised of local individuals, we're concerned that these same individuals are being appointed by cabinet as opposed to being elected.

These LHINs have taken the appearance of a pawn—created, hand-picked and controlled by the player. In this case, it's the government.

Smitherman has stated that decisions would be "based on priorities set in communities" and taken at open public meetings.

Our region of the province has been labelled the North West LHIN. The boundaries of this LHIN are from the Manitoba border, which is approximately 600 kilometres west of Thunder Bay, to White River, which is approximately 400 kilometres east of Thunder Bay. This LHIN's boundaries span 1,000 kilometres if travelled in a relatively straight line. However, let's not forget the communities north of Thunder Bay and the distances involved in reaching them, i.e. Nakina, which is roughly 400 kilometres north of Thunder Bay.

Section 9 suggests that LHIN meetings are to be public. Let's be realistic. Making meetings public is one thing; making them accessible is another. Being a citizen and living in northwestern Ontario, we often struggle with the ignorance associated with the vast size of our region. Let's be clear: We will demand that, if this bill is passed, these LHIN meetings be conducted in each community that may be affected by a decision.

Expecting someone to drive upwards of 1,000 kilometres to attend a local meeting hardly seems appropriate. I'm sure you realize how many communities are situated in our region and how many days or weeks it may take to conduct these meetings. I once again refer to Mr. Smitherman's comments: "priorities set in communities" and more responsive "to the needs" of the community. How can the government be more responsive or set priorities for a community if they don't allow an opportunity for the communities to provide their input?

The LHIN legislation is nothing more than the Ontario government's attempt to control health care costs by privatizing non-clinical services and integrating other services, meaning patients will have to travel hundreds of kilometres.

Forestry is the mainstay of many of our communities. Over the past few years, we have seen mill closures and drastic layoffs, with more anticipated. The effects to our local communities have been devastating. Many would believe that little has been done by way of government intervention, and what has been done has been too little, too late. Now it appears as though we will be facing another round of job losses and demolition of our communities.

The smaller communities within our geographical region will likely be affected the most, with services being moved to larger communities. If services are removed, undoubtedly it will result in job loss. It doesn't become an issue of moving from one employer to another or from one location to another; it's a matter of removing decent-paying jobs out of communities which have already been teetering on the brink of existence. Without decent-paying jobs, existence becomes futile. Individuals will be forced to abandon their communities and relocate to metropolitan centres such as Toronto or to another province. It's already occurring daily. We simply can't afford another blow to these communities.

Once jobs are gone, the residents will follow suit. What do you think happens to the community? It

naturally moves closer to extinction. We understand that it's hard for Ontarians living outside of northern Ontario to believe that houses are typically sold for \$20,000 to \$40,000 in some of these smaller communities. Who wants to move to a community that has nothing to offer? It's not even as though you could live in one community and commute to another because odds are that the community beside you has nothing to offer either, not to mention the significant distances between communities. Having said this, houses often do get sold. Americans and southern Ontarians buy and use these houses as summer getaways or vacationing destinations. After all, the hunting and fishing is superb. Neither Smitherman's recent speech nor Bill 36 protect loss of jobs in communities.

Once these services are moved to larger communities, they run the risk of being privatized. Remember, LHINs will be forced to contain costs, given their predetermined amount of money to provide services and an inability to run deficits. So now, our decent-paying jobs of \$33,000 to \$35,000 per year would be shifted to the for-profit private sector. The government may argue that the result is simply a shift in employers. But let's not forget: The private sector will not be bound by the collective agreement our members once enjoyed. Now they may only earn \$7.75 per hour, which is the most current minimum wage, which represents approximately \$16,000 per year—not acceptable.

The government is moving this legislation forward without having a strategic plan in place for the delivery of health care in Ontario.

The legislation is flawed because its premises are based on cost containment of health care services and not on ensuring that Ontarians have equal access to quality public health care services.

In effect, Bill 36 is nothing more than the Ontario Liberal government's cost containment strategy. Privatization schemes that will reduce human resources costs are the route the government has chosen.

Ms. Barb Rankin: My name is Barb Rankin.

The Chair: There's one minute left for your presentation.

1630

Ms. Rankin: Okay. I've been working with members of the service employees union for over 20 years, and one of the first meetings that I attended was a meeting with the government about restructuring health care. We sat down at that meeting and said, "We realize what you're doing." At that time, they were trying to move patients out into the community. We said, "You know what? We understand what you're doing, but there are some concerns and some issues." We laid them all out; we said, "For one thing, you don't even have the people in the community to take care of these individuals that you're going to move out, and secondly, we're concerned about how those members who are working in the hospitals," at that time making relatively decent wages—what was going to happen to them, because they would end up working for the private sector. We raised all those

concerns and we were told, "You know what? We're not going to privatize. Everything's going to be okay."

We know that everything's not okay. We know that those individuals working in the home care communities are making less money. They are, at times, we want to say, subsidizing health care for people who are receiving care in the community.

We're raising these issues because we see the same thing happening again. We see you putting forth this legislation and we think it's the same thing. It's a layer of bureaucracy, but what's that layer going to do? We don't see that it's going to help provide doctors or better health care or anything along those lines. Back then, we said, "There are some problems here. You have to go back and talk to people. You have to talk to the stakeholders and listen and get into the nitty-gritty." These meetings that you're having here are fine, but you're not having the nitty-gritty discussion that you need to have with the people we represent and many of the other unions as well.

I'm probably going past my one minute. I think we underestimated our time a tad. But we thank you for listening to us. There is more information in the brief. We are appealing to you to stop this legislation and go back to square one.

The Chair: Thank you for your presentation. Yes, we do have the materials. They will be part of the pile.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3253

The Chair: The next one is a teleconference. I believe Diane Atkinson is on the line.

Ms. Diane Atkinson: Yes.

The Chair: Ms. Atkinson, would you please start your presentation? You have 15 minutes.

Ms. Atkinson: Okay; thank you. My name is Diane Atkinson. I am a Marathon citizen who has worked as a front-line social worker for the past 21 years. I provide addiction, problem gambling and mental health services in Marathon. I am the president of CUPE, Local 3253. I am an elected official who sits on the CUPE, Ontario division, social services workers' coordinating committee, representing community agencies.

I'd first like to take this opportunity to thank you for providing this public hearing and making available the possibility for me to speak in standing before your committee using teleconference. As I mentioned in my request to stand, Thunder Bay, where the public hearing is being held presently, is 320 kilometres away from my community. In driving hours, that's approximately three and a half hours of straight driving. In winter weather in our district, highway closures are simply a way of life. In any season, travel is always a worry and a concern to those who are well. Just imagine if you have a health care need or if you suffer from mental health or addiction problems.

At first glance, when I referred to the local health integration network's geographical boundaries on the

website, all 14 areas appeared approximately the same. As northerners, we know that the first step to any geographical reference is to examine the legend and the scale used. I would first like to point out that the geographical area for the North West LHIN is extremely vast, and its scale is 150 kilometres to 45 millimetres. Only one third of our geographical boundary is accessible by road. The remaining two thirds of the map can only be accessed by plane. Many First Nation communities are not accessible all year round. To call the northwestern integration network "local" is misleading and negligible, to say the least. Further, to suggest that our small communities, or even more remote, that a citizen from within the northwestern integration network can have a significant voice in being heard or give direction at the LHIN board level is also misleading.

The power of the government in this proposed bill is far removed from allowing community input and continuing to provide community-based services. A LHIN is defined as an agent of the crown, and it acts on behalf of the government. LHINs are governed by the board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and the vice-chair of those boards. Each member continues on the board at the pleasure of the cabinet and may be removed at any time without cause.

The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may ultimately impose this, even if the LHIN does not agree to the agreement.

In addition, the LHINs' integration plans must fit the provincial strategic plan, so LHIN boards will be responsible to the provincial government rather than communities. This is in contrast to a long history of health care and social service organizations in Ontario that, as a rule, are not appointed by the provincial government. Our hospital boards, for example, are not appointed by the provincial government. They are elected by the citizens of their communities, those very people who live, work and use the services, the people who are there to advocate for community health care needs and who understand their community needs, and in our case, the reality of our geographical area.

Recently, however, the government has found a way to blunt criticism of underfunding and privatization. The key was to replace community boards with government-controlled boards. This, unfortunately, is the model of the LHINs. The result of this experiment in community care access centres, otherwise referred to as CCACs, suggests that it is a very poor model for LHINs to follow.

CCACs were taken over by the provincial government in 2001. CCACs immediately ceased pointing out to the public their need for adequate funding. The result: The funding was flatlined for years, and home care services were cut back dramatically. With these cutbacks, my clients—those receiving mental health and addiction services who are also in need of home care services from CCACs—saw their eligibility for services cut: baths cut

from twice per week to only once, or even eliminated. The time allotted for workers to spend with clients was significantly reduced, their homemaking services decreased or totally severed, and their isolation from their communities was further entrenched, leading them to more complications with their mental health. Now, clients complain of continued changes of workers, since workers are paid at lower rates of pay and the retention of quality workers is a problem.

Government-controlled regional agencies are a poor model for health care and social service reform, yet this is what we're facing. The LHINs structure puts up significant barriers to local community control for health care. Conflict between communities within our LHINs are likely, with small and very remote communities pitted against one another, and their already scarce services threatened or eliminated.

These serious problems suggest that another direction must be investigated. We need to provide for a democratic election of LHIN directors by all residents in the LHIN geographical area, with selection of the chair and the vice-chair by the elected directors. Local members of provincial Parliament should be ex officio directors of the LHINs. There should be a requirement in the bill for extensive public consultation on existing geographical boundaries of the LHINs. We need a ministerial obligation to meaningfully and fully consult the communities prior to imposing an accountability agreement on a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-unionized employees.

Bill 36 gives the LHINs and the government a wide range of tools to restructure public health care organization. First of all, the LHINs have their funding powers to facilitate consolidation. They also have accountability agreements with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and the cabinet to force consolidation. LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service.

The bill gives the minister even more powers to order integrations directly. Specifically, the minister may order not-for-profit health service providers to cease operating, to amalgamate, or to transfer all their operations. For-profit providers are exempt from this threat. The government refers to this restructuring as integration, stating that the goal is the creation of seamless care in a true health care system.

A key goal of this reform is to constrain costs by integrating services, but this also raises questions about cutting services in local communities. Community mental health services and addiction services are already integrated in our district, to a level where often accessibility is affected.

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In recent years, mental health and addiction services in our district have seen underfunding, budgets frozen, and

services amalgamated. Our district services already cover a vast area of 80,000 square kilometres, with community offices having been shut down and clients made to access services in neighbouring communities. Agencies have reduced worker travel and put in place restrictions on workers to provide the services to those in need due to high travel costs to small and remote communities such as ours, which service such a large geographic area. This may as well be the elimination of services, since many communities do not have the luxury of public transportation. Add to this the population that we serve. These are citizens facing mental health and addiction problems where often poverty and/or the very essence of their illnesses create isolation. To add travel to a nearby community to access services would only make their task insurmountable.

As a front-line worker, I service a population at their most vulnerable state, with few supports and options, often too unwell to have a political voice and be heard while decisions such as these are being made. These amalgamations have meant that clients have gone without services or have seen their services reduced to the point where one would question their effectiveness. Jobs and services have been cut, with workers being laid off, their positions eliminated or just left vacant. Integration will remove jobs and services from local communities, hampering access. Community services are under attack. Reduction in community control and provincial government accountability will make it easier for the government to implement these threats.

We need fundamental change. Provide in the bill that cabinet, the minister and the LHINs may only exercise their powers in the public interest, with "public interest" defined to include preservation of the public, not-for-profit character of our health care funding and delivery system. You must provide in the bill that transportation subsidies will be paid by LHINs if the required service is no longer provided in a given community. No purpose has been served if integration creates a new class of residents. Provide in the bill that nothing in the legislation authorizes cabinet, the minister or LHINs to override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements.

There are no provisions in Bill 36 which ensure, require or even encourage LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. Indeed, these bodies would now be armed with the legal authority to privatize large parts of our publicly delivered health care system. Competitive bidding is already doing damage in social services. With the introduction by Human Resources and Skills Development Canada, the new bidding process has, in the first round of proposals, disrupted over a third of the long-standing arrangements with community organizations. Laid-off social service workers are being forced to apply for their same jobs at a lower rate of pay and benefits.

Privatization and decreased co-operation between providers are major threats of this reform. Instead of integration, privatization will bring disintegration, with the

various providers in competition to win contracts. Specialization will increase inconvenience and travel for patients. In our district that creates far-reaching challenges for community citizens, with little or no access to public transportation, extremely long distances to travel, unsafe road conditions and continuous road closures.

The institution of the purchaser/provider split and the expansion of privatization in health care and social services should not be part of health care reform. Again, we need to rethink this reform. Health care and social service workers have been through many rounds of restructuring already, and we were always assured the various changes were for the best. But too much of this restructuring simply consumed enormous energy and resources, exhausting health care and social service workers. Yet we face change on an even broader scale now.

As the workers faced with this change, we deserve at a minimum a fair process that will provide reasonable employment security and protect working conditions, collective agreements and bargaining unit rights. The Canadian Union of Public Employees is closely examining the impact that Bill 36 and its use of the Public Sector Labour Relations Transition Act to deal with the labour relations issues raised. These concerns have most certainly been presented to the hearing by other committee members, and it has been made clear that employment security protection in our collective agreements cannot be overridden by this bill.

For all these concerns, this bill and the government's attempt to restructure health care needs to be rethought. We urge the government to take a considered and consultative approach. We believe that a better approach would be to consult with local communities, health care workers and the public about how health care should be reformed. That would be a much more satisfactory and democratic process.

I'd like to thank the committee for listening to the concerns of those I represent and to the suggestions I've put forward.

The Chair: Thank you, Ms. Atkinson. You took exactly 15 minutes, so there is no time for questioning.

Mr. Gravelle: If I may, Mr. Chair, I'd like to say hello to Diane. It's Michael Gravelle, Diane.

Ms. Atkinson: Hello, Michael.

Mr. Gravelle: Thank you very much for your presentation. I appreciate it. How are things going with the North of Superior programs?

Ms. Atkinson: Not too bad.

Mr. Gravelle: I'll come and see you soon.

Ms. Atkinson: Okay.

Mr. Gravelle: Thank you.

The Chair: Anybody else?

Thank you very much for your presentation.

THUNDER BAY AND DISTRICT LABOUR COUNCIL

The Chair: The next presentation is from the Thunder Bay and District Labour Council, Evelina Pan, president.

Good afternoon, Ms. Pan. You can start whenever you're ready.

Ms. Evelina Pan: Thank you so much. Thank you for the opportunity to present our concerns to the hearings on LHINs this afternoon.

The Thunder Bay and District Labour Council, for those of you who don't know—Michael and Bill do—represents some 9,000 union members in and around Thunder Bay, who work in every aspect of the economy, from manufacturing to mining, from service and retail to media, and of course in the public service.

We were very concerned when we first learned about the LHINs process last year, and the more we find out about LHINs, the more alarmed we have become. We're sure you've heard many of these concerns articulated all day today here in Thunder Bay and in the other communities that the committee has been to. We won't go through all the issues that cause us concern, but we'll highlight just a few.

Regional inequalities: As you've heard all day, only 14 LHINs will control most aspects of health care in Ontario. Do you have any idea how big the northwest LHIN is? Even the Ontario government's own website takes a page and a half—it looks like this—to list the communities, and it says, "This list is intended as an overview and may not be complete." Here's a map that gives a more graphic representation of just how big our LHIN is. Ours is the part that I've pinked in. The rest of the province, I've done the outline in pink. It takes up pretty well half of the territory, the land mass, of our province. As other presenters that I've heard since I got here after work have said, it's 1,000 kilometres this way, there are many communities north. Well, this is what it looks like. If you've spent any time here in northwestern Ontario, you'll know that during the winter, roads can be treacherous to drive on, and if you drive the speed limit, the six-hour drive from Thunder Bay to Kenora can take up to eight or nine, or more, hours, especially if the Trans-Canada Highway is closed for whatever reason—and that happens. It's not a big surprise when that happens.

There is some fear that with the development of centres of specialization, people in already underserved communities will be forced to travel many hundreds of kilometres to get the services that they were once able to access locally. For many seniors and others who live on small fixed incomes, the cost to travel from their home to another community might result in them not getting the care they need. The northern travel grant would have to be increased to include not only the patient, but someone to travel with them.

I just want to tell you a little story. I've written here a little story that's very sad, but true, that happened to somebody in northwestern Ontario not that long ago. A woman who was sick had to go to Toronto for treatment, so she and her husband flew down. He was also covered, because he had to accompany her. Unfortunately, she died. The government was so callous and uncaring that they said he didn't qualify for the travel grant on the return trip because he wasn't accompanying anybody.

Further, smaller communities may lose their hospitals because they won't be able to compete with larger hospitals, which can make purchases cheaper due to economies of scale.

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The next concern that we'd like to highlight is the responsibility of the LHINs. According to the government's website, the LHINs will be responsible for public and private hospitals, including the divested provincial psychiatric hospitals, community care access centres, community support service organizations, mental health and addiction agencies, community health centres and long-term-care facilities. At the same time, not all health care programs or all services will be covered. The not-covered ones include doctors, ambulance services, labs, provincial drug plans, independent health facilities and public health. It absolutely defies the imagination to understand how LHINs can purport to create an integrated health system without the inclusion of these major parts of primary health care.

If we also look at the Ontario government website, the list of programs and services takes four full pages to list. Again, there's a disclaimer at the bottom that the list may not be complete. So we're looking at addictions, children's treatment centres, community care access centres, community health centres, community support services—the list goes on and on for four pages, which I'm not going to read.

The competitive bidding model: We wonder if public health care providers will have to compete against each other for contracts, as is currently the case with the CCACs, and further, if for-profit health companies, including those from the United States, will have an increased presence in our Canadian system of medicare. We demand assurances that health care services won't be provided by the lowest bidder who wins a contract. We've seen the destruction of community-based not-for-profit home care in Ontario, along with increased private for-profit delivery, and the diminished level and quality of care provided to patients through this process. We are absolutely fed up with the health care model that orients itself on short-term financial goals at the expense of people and patients.

Workers' futures: In the home care sector, the competitive bidding model, which is proposed for the LHINs, has resulted in less care and a lack of continuity of care for patients as providers change when they lose contracts. What will be the impact on workers' wages and benefits, health and safety, and job security? Will health care workers have to reapply for their own jobs at a lower rates of pay and inferior benefits if the employer they work for loses a contract to an even lower bidder? How will workers' morale issues be addressed? What about workers' union membership and protection? Health care should never—never—be dictated by a race to the bottom.

Public accountability: This is something that I've heard a number of presenters talk about just in the hour or so that I've been here. As it currently stands, the LHINs legislation doesn't seem to allow for community

input or control, unlike school boards and municipalities, where the members of these bodies are democratically elected from the communities they represent. The LHIN board members are political appointments, with the chairs and vice-chairs being appointed by cabinet, resulting in their primary loyalty being to the government and not the local community.

Without some major changes to this legislation, we see the LHIN process destroying local control of health services, while creating a new massive and expensive bureaucracy that has no ties to local communities. The only beneficiaries are political careerists and predatory private health care corporations with absolutely no loyalty to patients, employees or communities.

Patient care: The McGuinty government prides itself on supporting our public health care system, but from what we can see, the LHIN system will actually undermine medicare by opening the door to increased private health care delivery through competitive bidding. How does it help patients when their health provider changes because they lost the job to a lower bid? For those of you who have family or friends who have faced this situation, you'll know that it takes time to develop a relationship between a patient and a caregiver, and part of the healing process is that good relationship.

A health service provider that is party to a decision by a LHIN may request reconsideration if they disagree with the decision. The LHIN has the power to make the final decision. Patients, community members and anyone who is not a party to the decision may not appeal. That is another patently unfair aspect of this legislation.

In conclusion, we ask the government to re-evaluate and review the plans for the LHINs and, instead, create an integrated health care system that emphasizes stability over chaos, fair treatment for all health care workers, democratic and accountable decision-making, and publicly funded, administered and delivered health care services.

Market-based health care is a proven failure in every jurisdiction it's been implemented in, especially as we can see in the United States, but also in Great Britain and New Zealand.

There's no public demand to undermine and dismantle the Canadian and Ontario community-based public health. What is required from the Ontario government is a sincere commitment to build on healthy foundations and to ensure proper funding for the health care system we cherish and demand. The McGuinty government has no mandate to complete the undermining of public health care that was initiated by the Harris government. Thank you.

The Chair: Thank you. We've got a couple of minutes, one minute each. Mr. Miller.

Mr. Miller: Thank you very much for your presentation, Emily.

Ms. Pan: It's Evelina. There's a typo.

Mr. Miller: Oh, I'm sorry.

Ms. Pan: But I'll actually answer to Emily. It's okay.

Mr. Miller: Thank you for correcting that.

And thank you for the sad story about the northern health travel grant. I'm afraid nothing surprises me about that, as I've had many experiences with trying to assist people who have been turned down. It seems to be one of the most bureaucratic programs there is in the Ontario government. Thank you for that story.

My riding is Parry Sound-Muskoka, so we're served by two LHINs, one being the North East LHIN, which I thought was pretty big because Parry Sound and James Bay are in the same LHIN. We have some fairly unique integration in our health system in the Parry Sound area right now. I'm concerned we're going to lose it with this process we're in right now, because with our hospital, the West Parry Sound hospital, we actually have the hospital, long-term care, the CCAC and nursing stations all under the same roof. Under the LHIN model, actually you move to less integration, I guess you'd say, because the six nursing stations that are under that umbrella, for some strange reason, are not under the LHIN.

I've certainly learned many of your objections. Do you have any suggestions for improving integration or suggestions for improving health care in the province?

Ms. Pan: I think the simplest answer would be to make things truly local, because when you take the decision-making outside of the community—and I know that Dr. Whitfield and the others on the LHIN are local people, but I don't recall anybody asking me if I would support that group. I don't recall any process by which the group was selected. In order for health care, education or municipalities to run in a sane and sensible way, there has to be accountability, and that gets to your question about any suggestions. There needs to be accountability. There needs to be—and you heard this this afternoon; even I heard it this afternoon and I've only been here for an hour—the participation of everybody who's involved in health care. And in order for that to happen, there needs to be a little bit more democracy in the process.

The Chair: Thank you. Monsieur Gravelle.

Mr. Gravelle: Evelina, it's good to see you, as always. You have very strong comments and I appreciate them.

In terms of the northern health travel grant story, it's a very true story. I was very involved in it and eventually we got the government to pay for the—

Ms. Pan: But it didn't just happen in—

Mr. Gravelle: It's a terrible story. That was a reflection of the lack of flexibility of the program, and I'll make my pitch now that I think we need to review the northern health travel grant and to build in some more flexibility.

Ms. Pan: Absolutely.

Mr. Gravelle: I know all my colleagues, but particularly Bill, support me on that.

My quick question, though—and Kathleen Wynne would like to ask a question too. You make reference to smaller hospitals closing. I think what we're going to be able to do as a result of the LHINs is actually enhance the services at the smaller hospitals in order to provide

better. You're going to have representatives who are going to be able to make the real case for why the McCausland Hospital, Wilson Memorial, which was recommended to be a district hospital—I see that scenario as being certainly as much of a likelihood as the one you're painting. Can you accept that possibility that I might be right?

Ms. Pan: I'd be very happy to accept that you would be right. But I could only accept that—

Ms. Wynne: He's usually right.

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Ms. Pan: He's often right. He's very often right. But I would accept that only if there could be assurances written into the legislation—cast in stone—that there would be sufficient money to make all these things happen. My worst nightmare is that money will be doled out January 1. Each LHIN will get X number of dollars to spend on the health care services that communities need, and come November 3, there ain't no more dough. People are still sick, people still need cancer treatment and people's elderly families still need care. What are we going to do? I don't see anything in the legislation that says there will be sufficient funds. One of the points that I tried to make in the presentation—but I guess I didn't do it very well—is to say that money should never be the guiding force by which health care, education or any other public services is delivered. If we deem the service to be important—and I don't think that there's a Canadian alive—maybe Stephen Harper aside, and Ralph Klein, certainly, but there aren't very many Canadians who would actually open their mouth in a public forum and say that the Canadian system of public health care is not one to be lauded, to be emulated, to be proud of and to be enhanced.

Ms. Wynne: Thank you very much for your presentation. What we're trying to do is to take powers and control that now reside in Queen's Park in Toronto and get them into the community. You noted that John Whitfield is from Thunder Bay. The other people who are on the LHIN so far—Janice Beazley from Fort Frances, Ennis Fiddler from Sandy Lake, Marlene Wong from Kenora, Kevin Bahm from Terrace Bay, Bob Ritchat from Atikokan—all of those people are much more connected to the community than ministry bureaucrats at Queen's Park. So I guess my question is, does it not make sense to you that those people are going to be more able to determine how the coordination of services should go in this area than people at Queen's Park?

Ms. Pan: Well, I don't know any of the other individuals. I do have an experience with Dr. Whitfield and I know that he spent a good number of years at Lakehead University. I don't think that he taught in health care; I could be mistaken. At the time that I had an experience with him, he was dean of—I don't even know what it was. I was in the library technician program at the university. That was before he became the academic—

Ms. Wynne: But would they not have more information? Even if you don't know them, would they not have more information than my friend who lives in

Mississauga who works in the ministry? Would they not know more about the community?

Ms. Pan: I'm not convinced of that, because you need to know the community, and that's why we're asking for the members to be democratically elected or at least selected from a pool, because for all the wonderful things that Dr. Whitfield and the rest of them have done, this is not their area of expertise. I don't think it's fair to put on his shoulders and the rest of the committee the responsibility of knowing all the health care issues in anybody's given community.

Ms. Wynne: I know I'm running out of time and the Chair's going to cut me off, but what we're also trying to do is learn from other jurisdictions. In Quebec, in Saskatchewan and in Alberta, where there were elected boards, there were not people stepping forward to take the positions. There wasn't a competency base and there weren't people willing to take it on. We're trying to learn from that and get the competency that we need on the LHINs.

Ms. Pan: Why can't we learn from the school board and municipalities model? That seems to work.

Ms. Wynne: That's another conversation I'd be happy to have.

The Chair: Thanks very much.

HELENE KELLY

The Chair: The next presentation is from Helene Kelly. It's a teleconference. Ms. Kelly, are you on the line?

Ms. Helene Kelly: Yes, I am.

The Chair: Would you please start your presentation, and thank you.

Ms. Kelly: My name is Helene Kelly. I am a registered psychiatric nurse working as a community mental health worker in Marathon.

I feel that if passed, Bill 36 will give government and the LHINs new and troubling power to restructure public health care and social services. The LHINs are local in name only and the bill would grant little power to the local communities and providers to make decisions. Rather, it transfers control to local community-based providers, the ministry and cabinet and their agents—LHINs—thereby centralizing rather than localizing control over health care in Ontario.

The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations. The government describes the legislation as a “made in Ontario” solution that would give power to the local level. It distinguishes the reform from regionalization in other provinces, as LHINs will not directly deliver services.

The LHINs cover vast and very diverse areas. The proposed LHINs are not local. They are not based on communities and they do not represent communities of interest. My community falls into the boundaries of the

northwest Ontario LHIN, number 14, which covers a vast demographic area and will create unique situations in regard to travel and increase stress on patients and families in their time of need. So it will be very difficult for people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

The autonomy of the LHINs from the government is very modest. With this bill, cabinet may create, amalgamate and dissolve LHINs. LHINs are governed by a board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and vice-chair of these boards. Each member continues on the board at the pleasure of the cabinet and may be removed at any time without cause. The government will control LHIN funding and the LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose this even if the LHIN does not agree to the agreement. In addition, the LHINs integration phase must fit the provincial strategic plan. So LHIN boards will be responsible to the provincial government rather than to local communities.

This is in contrast to the long history of health care and social services organizations in Ontario, which as a rule are not appointed by the provincial government. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were reversed and the hospitals were allowed to continue to provide decent care. Recently, however, the government has found a way to blunt criticism of underfunding. The results of this experiment in community care access centres suggests a very poor model for the LHINs to follow. The CCACs were taken over by the provincial government in 2001 and the CCACs immediately ceased pointing out to the public their need for adequate funding.

Tens of thousands of frail, elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 2001 to April 2003 and a cut of six million hours in service, a 30% drop. Many of my clients' services were reduced or declined by this reduction, and many were refused on the basis that they had family living in the community and therefore their family could provide the care. Unfortunately, mental health and addictions clients do not have strong bonds with their families or are being put in the position of being abused both physically and emotionally by having a family member provide personal care to them.

Government-controlled regional agencies are poor models for health care and social services reform, yet this is what we are facing. LHINs will insulate government from decisions to cut back or privatize services by creating another level of bureaucracy that will catch much of the flak. The government will control LHINs, but the LHINs will actually implement decisions. They will be the first targets for popular discontent, even if

their actual autonomy from government is more imaginary than real.

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The large, socially diverse areas covered by LHINs also suggest that there will be significant conflict over resource allocation. What services will be provided in each of the LHINs? Unlike government, LHINs will not be able to increase revenue. Smaller communities may be the first to see services integrated into other communities. The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely, with small communities particularly threatened. Likely, the provincial government will respond to complaints by stating, "It was not our decision. It was a decision of the LHIN," yet the LHIN will largely be unaccountable to the local communities. These serious problems suggest another direction to be investigated.

We need to provide for the democratic election of LHIN directors by all residents in the LHIN's demographic area, with election of the chair and vice-chair by the elected directors. Local members of the provincial Parliament should be ex officio directors of the LHINs. There should be requirements in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect real communities of health care interests so local communities can have a real impact on LHIN decisions.

We also need a requirement for real public consultation when government proposes to amalgamate, dissolve or divide a LHIN. We need a ministerial obligation to meaningfully and fully consult with the community prior to imposing an accountability agreement of a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee made up of union representatives and representatives of non-union employees. We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public. We need to ensure the right to seek reconsideration and for full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decisions or regulations.

Bill 36 gives LHINs and the government a wide range of tools to restructure public health care organizations. First of all, the LHINs have their funding power to facilitate consolidation. They also have the accountability agreement with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and cabinet to force consolidation.

The bill gives the minister even more power to order integration directly. Specifically, the minister may order not-for-profit health service providers to cease operating, amalgamate or transfer all of the operations. For-profit providers are exempt from this threat. The bill allows the cabinet to order the public hospitals to cease performing any non-clinical services and to transfer them to another organization. This means that the government can centrally dictate how all non-clinical services are to be pro-

vided by the hospitals, including through privatization. The bill gives cabinet the authority to contract out these services, despite the wishes of the hospital. There is no definition in the act of “non-clinical service,” and so this definition may be the matter of considerable controversy.

The government refers to this restructuring as integration, stating that its goal is the creation of “seamless care” and a true health care system, but this is misleading. The LHINs restructuring will not unite hospitals, homes, doctors, laboratories, home care providers and clinics as in other provinces. Worse, the LHINs purchase power model will increase competition between providers, and plans to spin work off for for-profit corporations, private clinics and regionally based support service providers will mean more fragmentation and less integration.

Integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reduction in community control and provincial government accountability will make it easier for government to implement these threats.

We need fundamental change:

(1) Provide in the bill that cabinet, the minister and LHINs may only exercise their powers in the public interest, with “public interest” defined to include preservation of the public, not-for-profit character of our health care funding and delivery system.

(2) Provide in the bill that LHINs, the minister and the cabinet cannot order or direct integration nor approve/disapprove integration. The power the LHINs have to withhold funding is power enough to encourage consolidation. The LHIN, the minister and cabinet should not have the right to transform the health care system unilaterally. Otherwise, there is no reality to the claim that we are enhancing local decision-making and no point in retaining provider governance structures.

The Chair: Thank you for your presentation. You’re already over the 15 minutes, but if you have any closing remarks, we’d be happy to hear them.

Ms. Kelly: I just want to thank you for the opportunity to speak. I feel strongly against this. I feel that we’re just leading to a two-tier health care system, and I find that frightening.

The Chair: Thanks again for your presentation.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.ON

The Chair: The next presentation is from the Service Employees International Union: Deborah Menzies and Maria Turco. Please have a seat. You can start whenever you’re ready. There’s 15 minutes.

Ms. Maria Turco: Good afternoon. My name is Maria Turco. I am a member of Service Employees International Union, Local 1.on. I have been working in clerical support at St. Joseph’s Hospital here in Thunder Bay for the past 34 years. In this time, I have seen many

changes. In my opinion, some were good and some were not so good.

I am here today to speak to you not only as a health care worker but also as a concerned citizen. There has been much talk about the government not wanting to privatize health care. If this is the case, then why are there private hospitals and P3 hospitals running in Ontario right now?

Almost \$200 million will be spent to set up a new LHIN bureaucracy. This will not add a single family doctor, specialist or direct, hands-on care provider to Ontario’s health care system. As we know, doctors are not even included under the LHIN legislation. It is almost impossible to find a family doctor. How are LHINs going to address this shortage?

How can spending this much money make health care better and easier to access for any ordinary citizen? Section 33 will allow the government to cease performing any prescribed non-clinical service and to integrate the service by transferring it to a prescribed person or entity. This section of Bill 36 gives the government the right to privatize more health services, particularly non-clinical services; for example, dietary, laundry services, housekeeping services and clerical services can all be contracted out, as these are considered non-clinical services. The broad definition of services and the right of the LHIN to move any non-clinical service means only one thing: the devolution of these services to for-profit providers. Therefore, this bill will be used to contract out non-clinical services, which will result in thousands of health care workers losing their jobs. Once jobs are lost, workers will not be able to file grievances through their collective agreements.

The Public Sector Labour Relations Transition Act will not apply where the Ontario Labour Relations Board issues an order declaring that it does not apply. In other words, the government wants to remove the protection of current collective agreements from health care workers. Displaced non-clinical service workers will have no right to transfer their union contracts to the for-profit private provider of non-clinical services.

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We have said that the Ontario government wants to use Bill 36 to control health care costs through the privatization of health care workers’ jobs. These workers, I want to remind this committee, are the least costly component of the health care system, yet we provide essential services that result in the smooth operation of a hospital. Even something as simple as not providing the proper diet to a patient could result in death or severe medical complications. Health care workers must be assured that our jobs, our wages and benefits, and our pensions are protected.

LHINs have already resulted in 42 district health councils being closed down and packages being offered to those displaced workers. Many of these workers will probably be hired in the new LHIN offices, of which there will be only 14. Are you telling me that all the displaced workers in 42 district health councils will be

given jobs in the LHIN offices? How will this save money? The only way I can see this happening is by cutting down services to the public. We are already waiting up to two years to see specialists and obtain much-needed services. How are LHINs going to effectively take care of this problem?

I do not think that anyone is averse to change when change will improve services; however, I do not see anything in the LHINs that will improve services. We still do not have enough doctors, wait times for tests and procedures are anywhere from six months to two years, and we now have to pay for eye doctor appointments, visits to the chiropractor and physio visits that are over and above the ministry's cap. How can we say that LHINs will be helping us when the services we had in the past are being cut? Will these new LHINs make health care more accessible and faster? How? These are some of the problems in our health care system. Where in Bill 36 do we see a plan for improving these issues?

Travel for people in the north is also a problem. How to get to an appointment, or a place to stay if undergoing tests, is a problem. We offer a service, but the costs of getting there and day-to-day living expenses are not the LHIN's problem. Some people have to travel anywhere from two to six and one half hours to obtain health care. What are LHINs offering people: publicly funded health care services or services that will cost thousands of dollars they do not have?

Mr. Smitherman said in his speech, "Not a single hospital is going to close on my watch. Period." If this is the case, why is this in Bill 36:

"Integration by the Minister

"28 (1) After receiving advice from the local health integration networks involved, the minister may, if the minister considers it in the public interest to do so and subject to subsection (2), order a health service provider that receives funding from a local health integration network under subsection 19(1) and that carries on its operations on a not-for-profit basis to do any of the following on or before the date set out in the order,"

And the very first one is,

"To cease operating, to dissolve or to wind up its operations."

If Mr. Smitherman is not thinking about closing any hospitals, why have this paragraph in the bill to begin with?

In closing, I do not feel that people react badly to change; people just react to bad change.

Ms. Deborah Menzies: My name is Deborah Menzies. I am a member of Service Employees International Union Local 1.0n. I work at Thunder Bay Regional Health Sciences Centre as an SPD operator. An SPD operator processes of instrumentation for surgeries that are performed at the hospital and provides sterile supply procedure trays to the rest of the hospital. I've worked at the hospital for 35 years in this capacity.

In preparing for this presentation, I looked at and pondered a number of issues and all sorts of different things that I could address, but I felt that others, certainly more eloquent than I, would talk at length about the

effect of this legislation on the delivery of health care, the status of current collective agreements and the social and economic effects on communities in Ontario. I felt that maybe it might be helpful and more appropriate that I talk to you about the experiences of myself and my co-workers in the health care system over the last many years.

Before I actually give you a flavour of what it is, and has been, like working in the health care system in the last many years, I want to comment on the whole process of how one deals with proposed legislation and discussions around that. I've noted that the government, in particular Mr. Smitherman in his presentations to this committee recently, talked about people who had different opinions than he and the government had with regard to LHIN legislation, that they were making an "attack" on the legislation. In my experiences in my work at the hospital, in my work as a steward and my benefits work, when we have a disagreement—whether it be a particular clause in a contract, the interpretation of that clause, or in regard to benefit issues where we're dealing with whether a person is deemed to be totally disabled or not—we have a discussion and a dialogue with regard to those issues and keep an open mind with respect to the folks whom we may not agree with, and at the end of the day we come to some type of resolution.

I'm offended that Mr. Smitherman would characterize someone not agreeing with his position or the government's with regard to LHINs as an attack on this whole piece of legislation. People have a right to make their position known, and the government has an obligation to hear that position and take into consideration the positions that are put forth, so that at the end of the day, the legislation crafted is the best legislation possible, legislation that will enhance the quality of health care of the citizens of Ontario.

Now I'd like to address some of the experiences that I and my fellow workers have had over the years in health care. One thing seems to be never-ending and repeated over and over again when they talk about health care: We in the support services areas—that is, housekeeping, dietary, SPD, laundry, RPNs etc.—feel like we're always being blamed for all the problems in the health care system because our wages are too high, and that everything can be solved by contracting out our services and reducing our wages. We don't feel we are the problem in the system. We feel that we provide a valued service to the system, whether it be the housekeeping aide who has helped develop a cleaning protocol for C. diff cases that has helped keep an infection rate down in our hospital, or the dedicated dietary help that prepares the meals for the patients in the hospital with care and with love and serves those very meals with care and with love.

The loyalty and dedication of those workers to the institution and to the health care system is immeasurable. Reducing our wages and putting the money in the pockets of contractors is not going to resolve the problems in the health care system. Governments have had difficulty addressing the problems in the health care system, problems that have existed for years, whether it be the escalating cost of medication, the cost of medical

equipment and medical devices, the physician shortage or the lack of accountability of the physicians in the system. Those very difficult issues are not seriously addressed by whatever the government of the day is. In fact, if they do make some type of effort with some of the problems, once there's any type of opposition or roadblock, particularly with regard to any issue related to physicians, every government in the past many years has backed down and left the docs for another government to deal with.

Something else that we in health care feel we've faced over the years is the issue of change, change in the system. Mr. Smitherman indicates his concern that people are resistant to change. We're not resistant to change. I can reassure him that we've seen change occurring in this health care system for as long as I've been in the system, working for my 35 years, particularly over the last 10 or 15 years. Yes, change is difficult, but people are open to the changes. What we get concerned about is that you don't change for change's sake. We've seen constant restructuring, where titles and names change over the years, over and over again. The question is: Is it any better at the end of the day after these changes? In most cases, no, because they're not addressing the real problems that are in the system.

Here's an example of changes at my hospital, Thunder Bay Regional Health Sciences Centre. In 1995, the two sites were merged, the McKellar site and the PA site. At that time, there was a whole restructuring of upper and middle management, and people were provided severance packages. At the end of the day, as time passed, what we saw was people being hired for these positions with a changed title, and the same people would end up coming back to the workplace with a different title. We then had to deal with the move to the new hospital, where there was the melding of the two different cultures into one workplace. The transition has taken place over time. Further, each department has since had to work at settling into a new work environment, with reconciling the differences between processes that came from each of the former sites. Add to that the constant updating of legislative requirements and various ministry directives and regulations. It has resulted in a constant state of change in an already stressful environment.

So we have been through and are constantly experiencing change, and there's not a resistance to it. Workers believe that there should be a positive outcome, something that would enhance the health care system. We look at the LHINs legislation and what we see is the government making changes that won't address the issues and the problems within the health care system. It's really frustrating for us, because we don't see it enhancing our quality of work life or improving the quality of care that the patients receive in the hospitals where we work.

In some cases, we see folks working in the health care field who have gone through their second round of severance packages because of the changes that this and previous governments have made in the health care system. From our perspective, it is wasting money, money that should be spent on hands-on patient care. The

LHINs legislation is not enhancing health, but instead is creating another layer of bureaucracy.

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I'd like to share with you now a story about my work in SPD over the 35 years. I was working at the McKellar site for most of the 35 years, until we moved to the new hospital. The department had SPD trays that go up to the floors; for example, chest aspiration tray, bone marrow, thoracentesis, paracentesis and closed chest drainage trays etc. Those trays were at the front of the department. Over 35 years that I worked, we had many supervisors and managers. The above-noted trays were moved around the department each time the manager or supervisor had a reason for moving them. As time went on, they were moved again and again, so by the time we were leaving to move to the new site, the Thunder Bay Regional Hospital site, lo and behold, they were right back to where they started 35 years earlier, right at the front of the department. It struck me at the time when we were leaving how ironic this was. Every manager and supervisor had their reason or rationale for changes they made. Did it make anything any better?

The Chair: Ms. Menzies, we want to hear you. Just slow down.

Ms. Menzies: Did it make anything any better? No. Did it enhance the service provided? No, it just moved those trays around. The point I am trying to make, and the question we have as front-line workers, is, what we see is the government with the LHINs initiative changing names, changing titles, but at the end of the day, the things you have proposed will not enhance nor improve the quality of health care in Ontario.

Something else that health care workers face, and have faced for many years, is the instability in the system because of all the proposed changes that governments make. In this particular case with LHINs, in the past there has been restructuring or whatever. It seems as if there has been restructuring for 35 years that I've worked in health care. This is disconcerting to people working in that system and very much a concern for the quality of the health care that's provided because of the uncertainty that the workers have with regard to their future, whether it be their jobs or the kind of work they're going to be doing, who they're going to be working for, what union is going to be representing them—all sorts of different things. This is disconcerting to patients because of the effect of these constant changes to the quality of their health care.

From my perspective in working as an SPD operator, the uncertainty we have does not help me to do the best job I can and being the best I can be, because somewhere in the back of one's mind, one is going to wonder, what's next; what's going to happen next? It's not any comfort to know that Mr. Smitherman, bless his little cotton socks, can say that nothing is going to happen, because we've noted that in the past these things have occurred in spite of what government officials may say. A politician or the government of the day will say one thing and sometimes something else will happen. As a SPD oper-

ator, I'm trying to pick my instruments and I should be focusing on that alone so that I can be the best I can be, that I can provide the service, that I can make sure the instrumentation I'm picking is the right instrumentation, that I'm putting everything together properly, that I'm making sure all the instruments are in the proper order, that they're in the proper working order, that they're clean and that they're sterilized properly. It is important that I be able to focus on that so the patients, when they're having surgery, have the best outcome possible.

This particular legislation creates the instability or uncertainty in the system. I've seen Rae days, I've seen health restructuring, but I've never seen anything that worries myself and my fellow workers more than this LHINs legislation because of the uncertainty and the instability it has caused and is causing in the health care system.

Is LHINs legislation a value added to the health care system? What is the true cost of this extra layer of bureaucracy called LHINs? Does the Liberal government believe in the public health care system? You note that I am asking, do they believe in a public health care system? I'm not saying do they believe in a publicly funded health care system, but does the Liberal government believe in a public health care system? Does the Liberal government respect the various collective agreements that have been negotiated by the union groups over the many decades?

In closing, I leave with you something to ponder. It's from a book called *Somebodies and Nobodies: Overcoming the Abuse of Rank*, by Robert Fuller. Who are the nobodies? Those with less power at the moment. Who are the somebodies? Those with more power at the moment. Power is significant by rank in a particular setting. Somebodies hold a higher rank than nobodies in that setting, for that moment. A somebody in one setting can be a nobody in another, and vice versa. A somebody now might be a nobody a moment later, and vice versa. Abuse of power inherent in rank is rankism. When somebodies use the power of their position in one setting to exercise power in another, that's rankism. When somebodies use the power of their position to put a permanent hold on their power, that too is rankism.

Dignity is innate, non-negotiable and inviolate. No person's dignity is any less worthy of respect or any less sacred than anyone else's. Equal dignity requires equal opportunity. Rankism is an indefensible abridgement of the dignity of nobodies and a stain on the honour of somebodies. As once and future nobodies, we're all potential victims of rankism. As would-be somebodies, we're all potential perpetrators. Securing equal dignity means overcoming rankism.

Who are nobodies? They are every man, every woman and every child. Each of us dreams of becoming someone new, something more. The nobodies are us. Therein lies our power. Nobodies of the world, unite. We have nothing to lose but our shame. Respectfully submitted.

The Chair: I don't think there is any time left of the 15 minutes. We thank you for both presentations, ladies.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 715

The Chair: The last presentation for the evening is from Dave Gibbons. Good afternoon. Thank you for coming. You may start anytime, sir.

Mr. Dave Gibbons: Good afternoon, Mr. Speaker. My name is Dave Gibbons. I'm a biomedical technologist at Thunder Bay Regional Health Sciences Centre and I repair medical equipment. I'm also the president of Ontario Public Service Employees Union, Local 715.

I represent approximately 360 hospital professionals and about 30 maintenance workers. The workers I represent, and I'll give you just a short list of some of them, are registered laboratory technologists, registered diagnostic technologists, social workers, biomedical technologists, psychologists, kinesiologists, dietitians, electrocardiology technicians, registered respiratory therapists, morgue attendant technicians, ultrasound technologists, nuclear medicine technologists, electroencephalographic technicians, child care workers, speech therapists, electricians, plumbers, physiotherapists and pharmacists etc. There are a lot more in this group. In this capacity, I have been able to hear the concerns of hundreds of health care workers about these LHINs. I am pleased to share with this committee some of the views these workers have.

Health care professionals are opposed to the regionalization of care when it involves the movement of hospitals from public to private and from near to far.

I'll give you a quote from Ian Urquhart of the *Toronto Star*: "What the government has in mind here is the consolidation of services now being offered in many hospitals in a region—say, cataract removals or hip replacements—into just one hospital or even a doctor-owned clinic...."

"Now, all this is fine provided you are not either a hospital employee ... forcibly transferred, or a patient who has to travel 100 kilometres for a routine procedure."

As my sister from SEIU stated, I was also involved in the amalgamation of the McKellar General Hospital and the Port Arthur General Hospital in 1995. I can tell you that there is still resentment about a forced amalgamation, and it will take generations before that disappears. The new hospital, the Thunder Bay Regional Health Sciences Centre, was probably the best solution for that amalgamation.

In the Thunder Bay district, the biomedical technology area has provided biomedical services for regional hospitals for about 16 or 17 years. This service was taken over by the hospital because a private contractor could not provide satisfactory service. I know this for a fact because I was the manager at that time. I instituted the service. The big complaint was that they were only getting one or two hours a day of service because they did not have enough time to repair medical equipment. As the manager, I promised that we would give them a full eight-hours-a-day service, and that was provided by the Port Arthur General Hospital at that time.

With LHINs, this service could disappear back to a private contractor. This results in a constant turnover of service, a lack of continuity, low wages, shortages of skilled workers, high cost and a shift to for-profit delivery.

1740

Just before Christmas, the union, OPSEU Local 715, was notified that there were layoffs in different departments. It seems that Thunder Bay Regional Health Sciences Centre is being compared with hospitals in southern Ontario. I believe that this is wrong because of the vast differences in distance between towns in southern Ontario and the northwestern Ontario region. If someone from Kenora needs a routine procedure, that patient may have to drive 6.5 hours to receive that procedure. As Evelina Pan pointed out, try that in the winter in the middle of snowstorm. Travel costs will effectively create a two-tier system: Those who can afford to travel will receive timelier health care.

In the north, hospitals are a major part of the community. The community's tax dollars went to build these hospitals, and these tax dollars are provided with the belief that each hospital will provide for full service. Services in the area hospitals with the LHINs will be rationalized and moved around. With LHINs in place, this will happen more and more frequently as LHINs are forced to rationalize and centralize services and contract out to the lowest bidder.

A good example of this is the Northern Ontario Business Services project. This project is under way so that hospitals may share resources and reduce costs. The areas that are being looked at are: information technology; biomedical engineering, which I work in, or clinical technology management; human resources; payroll; and scheduling and PACS, which is picture archiving and communications systems. This project may have some merit, but it's hard to imagine a biomedical engineering department in Thunder Bay being managed by a manager in Sault Ste. Marie.

Ironically, the sector repeatedly targeted by the Minister of Health is the hospital sector. It's ironic because the hospital has been the star performer in Ontario's health care system. Ontario has fewer hospital beds per capita than any other province. The Hay Group's March 2004 study also said that Ontario's hospitals are more efficient than others in Canada. The report showed that Ontario hospitals have a lower potential for finding additional savings than others in Canada—a reminder of the efficiency measures already taken by our hospitals.

Now, once again, our members are being asked to cope with chaos created when the whole system is amalgamated, merged, rationalized and bent every which way in the interest of trying to squeeze every last possible dime out of the system. I see shades of 1995 and the hospital mergers.

This system will have a negative effect on skilled labour. Look at home care and how it has been devastated. Home care is simply not a career option anymore thanks to the competitive bidding system put in place by

the Mike Harris government. We do not want to see the same thing in hospitals.

We wonder if this is integration or something else you may call it. While the government presents LHINs as a solution to the integration problem within the system, essential parts of the system remain outside this model. These include physicians; ambulance; private laboratories and specimen collection outside the hospital; public health, despite the lessons learned from SARS; independent health care facilities; homes for special care; provincial drug programs; psychiatric hospitals still under direct control of the Ministry of Health; and defined specialists such as podiatrists and optometrists. In southern Ontario, the regional laboratory known as EORLA, which is 16 labs that have been downsized to one, and other similar structures are out, although they provide services to all the hospitals. This service will eventually make its way to Thunder Bay. How do you integrate a system when so many important services are outside?

This inconsistency will mean more fragmentation for small communities, such as Nipigon, Terrace Bay, Atikokan and Marathon, than presently exists. Ironically, the LHIN legislation actually encourages transfers to these organizations that are outside the LHINs—or was this really the intention? However, for those workers affected, there are many huge questions that have not been sufficiently answered.

In the last round of hospital restructuring, the Health Services Restructuring Commission recognized the need for human resources adjustment plans to be negotiated with the unions. This time, there is no human resources strategy at all. The majority of hospital professionals believe that this is a priority, and still it is ignored in the legislation. There is already a huge retention and recruitment problem for all health care professionals and others, and this legislation is going to make it worse. Try to get summer holidays when there is insufficient help for summer replacement. When I have talked to others, some have said, "If I had to choose a career all over again, I would not choose a career in a hospital."

We, the hospital professionals, are already wondering who will do the work in a few years' time, when so many of us are eligible to retire. Many of the schools for hospital professionals have been closed over the past 10 years. With so many couples where both are working, who is going to relocate to another community? My wife has worked for the hospital for 35 years and I've been in it for over 20 years. In a lot of these cases, you'll find that there are couples who both work in the hospital. What's going to happen when these departments are broken up?

The province must negotiate a human resource adjustment plan and it should be willing to substantially fund these plans. These human resource plans should include: layoff as a last resort; measures to avoid a layoff; some voluntary exit opportunities; some early retirement options; pension bridging; retraining options; and more classroom space for more students. A transitional fund

should be put in place and a health service training and adjustment panel should be resurrected.

This legislation should not go forward without a human resources plan. Without health care workers, you have no health care.

That's the end of my presentation.

The Chair: Thank you for your presentation. Does anyone want to ask a question?

Ms. Wynne: Sure. A couple of things. I just wanted to comment that the Ontario Hospital Association is supportive of this change, so it's interesting to me that the support of hospitals is coming from people who I guess are not in sync with what the hospitals themselves are saying about the need for this kind of coordination in the system. That's one piece.

The other piece is the whole issue of privatization, which has come up over and over again over the last four days, and I'm sure will continue to come up next week. There's nothing in this bill that says we're interested in increasing the privatization of the system. There just isn't anything there. There's a section 33 that is a transitional section. When we talk about non-clinical services being contracted out, that's not new in the system. As far back as the NDP government in 1991, 1992, 1993 and 1994—St. Thomas-Elgin General Hospital, Trillium Health Centre, Halton health centre, Joseph Brant Memorial: In all of those hospitals, ancillary services were contracted out.

What we're talking about is nothing new, and I guess the benefit of this system, to our minds, is that there will be an opportunity for people at the local level to have access to a discussion about planning that they do not have access to now. That's the point of this legislation, to give people access to a planning process that nobody in the province who's not in the ministry at Queen's Park has access to right now.

That's all I wanted to say, but I hope that message can get through because that is the intention of this minister in putting this legislation forward.

Mr. Gibbons: Excuse me; you didn't introduce yourself to me.

Ms. Wynne: I'm sorry. I'm Kathleen Wynne. I'm the member of provincial Parliament for Don Valley West in Toronto and I'm a member of this committee.

Mr. Arnott: I just want to express my appreciation to you for your presentation this afternoon. You've added a great deal to the discussion. Thank you very much.

The Chair: That's Ted Arnott. He's also a member of provincial Parliament.

Thank you. That takes us to the end of today's meeting.

We will adjourn until Monday at Queen's Park, when we will continue three additional days of deputations.

We thank you for joining us in beautiful Thunder Bay.

The committee adjourned at 1750.

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of Ontario**

Second Session, 38th Parliament

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Lundi 6 février 2006

**Standing committee on
social policy**

Local Health System
Integration Act, 2006

**Comité permanent de
la politique sociale**

Loi de 2006 sur l'intégration
du système de santé local

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 6 February 2006

Lundi 6 février 2006

*The committee met at 0901 in committee room 151.*LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

The Chair (Mr. Mario G. Racco): Good morning. Today we will start right at 9. I welcome all of you to our fifth day of presentations. Today, tomorrow and Wednesday will be the last three days of presentations here in Toronto before we end this set of discussions with the community.

CITY OF TORONTO

The Chair: The first presentation this morning is from Toronto city council.

Mr. Joe Mihevc: Good morning.

The Chair: Good morning, Joe. How are you?

Mr. Mihevc: Good. How are you?

The Chair: Very well, thanks. Please have a seat. You have 15 minutes, as you know, and if there is any time, there might be an opportunity for questions and/or comments for you. Please start any time you're ready.

Mr. Mihevc: Thank you very much. We have a written submission as well.

The Chair: Yes, we all have it.

Mr. Mihevc: Great, thank you.

The city of Toronto is very pleased to take this opportunity to comment on and provide suggestions on improving Bill 36. My comments take place within the context of Toronto's knowledge of our city's diverse communities, our respective governments' responsibilities for the well-being of our residents and our developing culture of partnership—a culture of partnership between the province and the municipality based on mutual respect and co-operation, as embodied in the recently introduced Bill 53, the Stronger City of Toronto for a Stronger Ontario Act.

This government-to-government context provides the province of Ontario and the city of Toronto with an opportunity for achieving a common direction for the

reconfiguration of local health services, a direction which is currently missing in the Local Health System Integration Act. As I said, the full document outlines Toronto's interest in a strong integrated health care system.

In my presentation, I will outline a number of recommendations from the city for making local health services integration work. Our most important recommendation is that the province recognize that the best possible solution for the city of Toronto is one local health integration network, or LHIN, whose boundaries correspond with those of the city of Toronto. If this model is not possible, and because right now Toronto is divided into five different LHINs, Toronto proposes that the legislation include a mandatory five-LHIN-city of Toronto collaborative table composed of equal representation from all five LHINs and Toronto to engage in joint decision-making about those services currently included in the LHIN legislation that are operated by or receive funding from the city.

What is our context? Toronto has a long-standing dedication to ensuring that city residents have access to appropriate health and social services. This requires careful planning and systems management as well as our share of funds to support the provision of high-quality, timely, effective and accountable services. In a sentence, we need to be able to also plan, develop and deliver city-wide services on a city-wide basis.

The main health services that the city funds, plans and provides are homes for the aged and its associated community programs, emergency medical services and, of course, public health. The city funds and directly operates both LHIN-funded and non-LHIN-funded health services. In one of the appendices here, you have a description of the full scope and role of these services. It should be noted that Toronto Public Health is a non-LHIN-funded service, and the board of health has adopted an official position that public health not be funded by—it isn't in the legislation now, but even at a future date—or report to a LHIN either now or in the future. Our feeling there is that it has been such a good relationship to link public health with the local provision of a municipal service, that that has been a long and great tradition in the city of Toronto. Toronto also funds a number of community agencies through its grants program. Many receive funding from the Ministry of Health and Long-Term Care and may be affected by the LHIN reorganization.

As Canada's largest and most diverse city, Toronto's health services must be prepared to meet the needs of city

residents from a wide range of income levels and linguistic, ethno-racial and cultural backgrounds. Because the city is a major urban economy which supports an extensive network of health and social services, it has a large population of people who are vulnerable due to income, age, recent arrival to Canada or disability. We give a sense of the demographics in the second appendix.

The city of Toronto supports and acts on the stated local health integration network goals of improved access to coordinated health care through effective and efficient local management. However, the legislation as currently written has significant barriers that will affect the city's ability to continue to achieve those goals, and at the same time will weaken our role as a government in funding, planning and providing services to people living here.

Our four main concerns, covered more fully in the complete document, are again:

The configuration of the LHIN boundaries: Toronto is served by five boundaries, as you can see from the map that I'll just show you here for a second. Only one LHIN is totally contained within the city's boundaries, the south central one. The other four LHINs have a reach far outside Toronto with areas that do not share the same large urban health and social service issues. As an example of impact, our homes for the aged and associated services will report through five separate entities for planning and funding purposes. This is going to be extremely difficult.

The second issue of concern is intersectoral planning and community development. At the local level, services do not operate in discrete silos but work in strong partnerships to provide health care and related services. For example, at present a municipal home for the aged in one of the four outlying LHINs of the city may collaborate with a service provider in a downtown LHIN for purposes of providing a particular type of program. In the new configuration, the home and the partner service provider will be in different LHINs. Similarly, partnerships may emerge between LHIN-funded and non-LHIN-funded service providers; for example, a public health unit and a community health centre.

Bill 36 is based on a direction of permeable boundaries which in practice should allow these relationships to continue. However, the legislation does not ensure that organizations will be able to collaborate or engage in joint service provision if the funding and planning for each resides in separate entities, or if one organization is funded via a LHIN and one is not.

The third issue of concern is community engagement processes and the community advisory committee. Although one of the activities of the LHINs is to engage the local community about needs and priorities, the only obligation currently in Bill 36 is that the local integrated health plan will be made public. This limited approach will weaken the community empowerment essential to building strong health care. Community involvement and outreach, such as that which takes place in our homes for the aged, makes service truly community- and consumer-focused. While there is nothing in the legislation that will

prevent the continuation of community and consumer engagement activities, the city believes that this should be mirrored in the LHINs themselves.

In addition, Bill 36 provides the Lieutenant Governor in Council authority to add services to the LHINs without consultation, running counter to the language and presumably the intent of community engagement.

0910

The fourth major concern is the health professionals advisory committee. Although Bill 36 does contain a provision for a health professionals advisory committee for each LHIN, there is no requirement that these committees include experts in geriatrics and long-term care, public health and other associated non-LHIN-funded health and social services.

In summary, the proposed legislation impedes rather than promotes city-wide integration, diminishes Toronto's role as local government, and does not provide for sufficient community participation in decision-making. Toronto has sophisticated and detailed service plans in all sectors and needs the ability to implement them. There is also concern about potentially weakening the city's inter-sectoral and community partnerships, two of the pillars of our health services implementation.

How much time do I have left, Mr. Chair?

The Chair: About four minutes.

Mr. Mihevc: Okay. There are some other concerns that we have, but they're really basically in the written presentation. Maybe, because of time, I'll just jump to the conclusion.

The potential in a Stronger City of Toronto for a Stronger Ontario Act provides both governments with an opportunity to improve the direction set out in Bill 36. Communities are strengthened when public services have coterminous boundaries, hence Toronto's preference to be covered city-wide by one LHIN. We respect and support the intentions of Bill 36, and we believe that improvements can be made to strengthen community planning and service provision within the boundaries of the city of Toronto. We are of course prepared to work with you towards that end as an order of government.

The Chair: We have a minute each for comments and questions. Madam Witmer, would you like to start?

Mrs. Elizabeth Witmer (Kitchener-Waterloo): Yes. I'd like to thank you very much for an excellent presentation. You've certainly identified one of the concerns we have, and that is the fact that the city of Toronto, unfortunately, is broken up into so many different parts. Do you believe that the recommendation you have put in place will totally resolve that issue?

Mr. Mihevc: No, frankly. We—

Mrs. Witmer: What's your preference?

Mr. Mihevc: I think it would be a concession, knowing that the train has somewhat left the station, that a lot of the infrastructure has already been set up. That's why we put in the caveat that if this model of one LHIN for the whole city of Toronto is not possible, then certainly there has to be something mandated in the legislation to at least have the service providers of the five LHINs

covering Toronto working together so that our homes for the aged work and associated work in social services—so you have the same level of services, in quantity and quality of service, in Scarborough as you do in Etobicoke and North York and downtown Toronto. The best, of course, would be one LHIN. I think people see themselves as Torontonians, and the magnetic pull, say, for example, in Scarborough will be towards the east and as far away as Peterborough. From a Toronto perspective, that really doesn't make sense. However, if that is not possible—and I recognize the reality of what's before us—then certainly something needs to be mandated into the legislation to get the five serving Toronto at one table working on service planning for Torontonians.

The Chair: Thank you very much. Madam Martel?

Ms. Shelley Martel (Nickel Belt): Thank you for being here this morning. I want to follow up on that, because you're right: The train certainly has left the station. We're dealing with legislation when in fact LHIN offices have been established and people have been appointed as if the legislation were already passed.

The minister has tried to say that the boundaries are based on hospital referral patterns, except that we've heard during the course of the hearings that people would be travelling to hospitals that normally they haven't before. For example, people from Sarnia are now expected to go to Windsor, when in fact the referral pattern was to London, so that doesn't make much sense either. The legislation certainly didn't take into account at all referral patterns for community services that were already in place, for example city of Toronto community services. Can you just reiterate again the services that are already well-coordinated in a pattern within the Toronto boundary that could well be disrupted (a) if there's no change to one LHIN—and clearly there won't be, because the offices are already set up—and (b) if there is no really concentrated effort to ensure that those five LHINs within the city boundaries actually work together, bearing in mind that some of those LHINs have boundaries that are outside the city boundaries anyway?

Mr. Mihevc: I think the biggest area that will be captured in the LHIN system for us as the city of Toronto is homes for the aged. We have a very good and developed homes for the aged network of 10 homes covering the city of Toronto. And of course we have a very good community network base for that as well, with community consultation committees that make sure that the level of service is high and that there's a lot of community and civic engagement for them. We are frankly proud of the homes for the aged offering as good a quality of service as anywhere. The fear here is that with Toronto being broken up into five distinct areas, there will be a different quality and perhaps quantity of service for the people in the homes for the aged in Scarborough versus homes for the aged in Etobicoke or north Toronto. I don't think that's a healthy thing. Poor Sandra here, who is the director of our homes for the aged, if she's trying to get some kind of equity of service and to know how we, as municipal service providers—

because we kick in tens of millions of dollars to the homes for the aged. To make sure there's an equity of service, she'll have to be bouncing around to five different boards to make sure their budget concerns are addressed, filling a gap here, filling a gap there, filling a different kind of gap depending on the area. That's why, if you can't go with the one LHIN, make sure that at least there is something built in so there's one table that the city of Toronto folks would have to go to to make sure that we have a coherent, good, well-planned, appropriately funded system across the city.

The Chair: Thank you. Ms. Wynne?

Ms. Kathleen O. Wynne (Don Valley West): Thank you. Welcome, Joe. It's nice to see you. I take your point about the homes for the aged and the need for inter-LHIN communication. There is nothing in the legislation, as you said, that would prevent that kind of communication. The whole thrust of this bill is about better planning and fostering collaboration.

In terms of the city of Toronto being discrete, I know that in my riding, and I think in your ward, the reality is that people from outside of Toronto refer to and need the services in Toronto all the time. What the LHIN boundaries recognize is those referral patterns and the reality that Toronto has to relate to the rest of the province. I think that's an important piece that we can't lose.

The question I have for you is that in section 16 of the bill, there's the issue of community engagement. What do you think we should put in the bill to be more explicit about how to engage the community? That's something the city of Toronto has done very well and it's something the minister is interested in having more specifics about, so could you give us a bit of direction about what you think we should have in terms of specifics around community engagement?

Mr. Mihevc: I'm not that familiar with the details of that particular section.

Ms. Wynne: Well, the section is very broad and basically says that each LHIN will have a mandate to engage the community in its planning process. You could get back to us later, but what are some of the things that you think we might do? You said you didn't think the community engagement section was specific enough, so what could we do to make it more specific? That would be a helpful amendment.

Mr. Mihevc: I'll refer that to staff. I think they're better placed.

Ms. Julie Mathien: We have recommendation 3 in our document, which is that each LHIN be required by legislation—because you don't have that now—to have a community advisory committee of its board and that details regarding the community engagement be specified in the legislation; and furthermore, that part III of the legislation be revised to mandate full community consultation before you add services to the LHINs. If, for example, you wanted to add EMS or something like that in five years, that would not be a stroke of the pen, as is currently provided for in the legislation, and there would actually be a full consultation process for that.

Ms. Wynne: That's helpful. Thank you.

The Chair: Thanks very much for your presentation.

0920

CATHOLIC HEALTH ASSOCIATION OF ONTARIO

The Chair: The next presentation is from the Catholic Health Association of Ontario. There are four individuals: Ron Marr, Jeff Lozon, Major Dennis Brown and Peter Lauwers. Good morning to all. You can start any time you're ready.

Mr. Ron Marr: Good morning. My name is Ron Marr and I'm the president of the Catholic Health Association of Ontario. I thank the committee very much for providing us with this opportunity to speak with you this morning. Joining me is Jeff Lozon, who is the past chair of the Catholic Health Association of Ontario as well as the president of St. Michael's Hospital here in Toronto; Peter Lauwers from the firm of Miller Thomson; and Major Dennis Brown, the CEO and president of the Salvation Army Toronto Grace Hospital.

The Catholic Health Association of Ontario, as many of you know, is the umbrella group that represents the Catholic health ministry in this province. Our members are Catholic hospitals, long-term-care and mental health facilities and community health services in the province. There are 29 such organizations operating on 39 sites. Our members operate large teaching hospitals, long-term-care centres and psychiatric hospitals in our major health science centres, as well as small facilities in mid-size and rural communities across the province. Also included in our membership are the seven religious communities of sisters and lay groups that sponsor these facilities, and the Ontario Conference of Catholic Bishops.

Catholic health services strive to provide the highest quality care with respect and compassion to all of those in need regardless of religion, socio-economic status or culture. We collaborate in open partnerships with other members of Ontario's health care system, and we are dedicated to voluntary governance to ensure accountability to the government and to those we serve.

Our members have more than 160 years' history of providing exemplary care. We have an outstanding record of good stewardship and have taken leadership roles in many areas of need. Catholic facilities reflect a proven, community-based, voluntary approach to governance. Our boards of directors are representative of the cultural, linguistic, socio-economic and religious composition of the communities in which we are located.

We have clearly stated the intent of the partners in Catholic health care to remain active participants in all sectors of Ontario's health care system into the future and to work collaboratively for positive change and progress. As active participants, we recognize and applaud the government's desire to preserve medicare for the future well-being of all Ontario residents, and also the government's commitment to a system where public accountability and the shared responsibility of consumers, health

service providers and governments are important and fundamental components.

Over the last number of years, the leaders of all three political parties in Ontario have shown their support for this faith-based approach to health care. Indeed, in an August 2003 letter to us, Premier McGuinty said:

"The Ontario Liberals recognize the invaluable contribution that the Catholic Health Association ... and the caregivers you represent have made as partners in the delivery of quality health care in our province.

"As I have stated in the past, the Ontario Liberals are committed to preserving the Catholic health ministry in our province. We appreciate that governance issues are of the utmost importance if Catholic hospitals, long-term-care facilities and home care providers are to preserve their ministry."

I'm going to call on Major Brown to say a few words, and then we'll get to the specifics of the bill.

Mr. Dennis Brown: Thank you, Ron. As president and CEO of the Salvation Army Toronto Grace Hospital, I want to appear here this morning in support of what the CHAO is doing. The Salvation Army of course is one of these faith-based providers, and we operate not only hospitals but long-term-care facilities, mental health programs, addiction and a wide variety of other social services. The Salvation Army and the Grace are committed to improved health and health care and really recognize the benefits that integrated systems provide, so we really want to work with you to make sure this legislation reaches its potential.

We want to affirm as well that within the evolving world of health care, faith-based providers do have an ongoing role. On the one hand we have the history of excellence, and on the other hand our desire to find the gaps and to respond to the needs of people who are marginalized and the most vulnerable. That really has something to offer in the new LHIN environment. I think that ongoing partnership with government and with the LHINs is really symbolized by the recent announcement of the Salvation Army building a new specialized hospital in this province as an integral part of the LHIN.

So we're really grateful to the CHAO for their work and we support their brief. I'll mention in passing that you've got the OHA later today and you had the Ontario Association of Non-Profit Homes and Services for Seniors. We also support their briefs, but I'm not going to take up your time going over more here. I'll pass it back to Ron.

Mr. Marr: Thank you very much, Dennis.

I have a few comments on Bill 36 for myself, and then I'm going to ask Peter to comment specifically on a section that we have some very real interest in.

First of all, CHAO supports the public policy goals of Bill 36. We support equity in health services across Ontario, better co-ordination of health care services, and accessibility. We also support effective and efficient management of the system. Bill 36 continues to respect the unique missions of health service providers, the voluntary nature of governance and the importance of local

control by local communities. Bill 36 represents a made-in-Ontario solution that avoids the regrettable and paradoxical centralization that has accompanied regionalization elsewhere in Canada.

CHAO particularly supports the preamble to Bill 36, which acknowledges “that a community’s health needs and priorities are best developed by the community, health care providers and the people they serve,” and the evident commitment in the preamble of the government to “equity and respect for diversity in communities.” The members of CHAO are deeply committed to voluntary governance, as I’ve said consistently, and we believe voluntary governance best reflects accountability to the local community and best accommodates diversity.

A few comments on part IV of Bill 36 in regard to funding and accountability, and the accountability agreements in particular: Our written brief provides you with a substantive background and details for our comments on accountability agreements. We talk there about the process that was used under Bill 8, specifically for hospitals. Because of time restrictions this morning, I will simply summarize our recommendations on the accountability agreement process that is envisioned in Bill 36.

There are several features of the hospital accountability agreements that I wish to point out to you and remind you about. First, the Ontario joint policy and planning committee, in its statement on accountability dated August 2005, states, among other things, that the following commitments are fundamental to the success of the hospital accountability process. Two items on that list that we support and refer you to are, first, “The negotiation, content, and implementation of accountability agreements will respect the governance of hospitals by voluntary boards of directors,” and second, “The negotiation, content, and implementation of accountability agreements will respect the diversity of hospitals, including any geographic, teaching and research, size or denominational considerations relating to the delivery of hospital services.”

In addition, the draft accountability agreement templates themselves provide, in specific reference to denominational hospitals: “For the purpose of interpreting this agreement, nothing in this agreement is intended to, and this agreement shall not be interpreted to, require a hospital with a denominational mission to provide a service or to perform a service in a manner that is not consistent with the denominational mission of the hospital.”

Bill 36, as you know, will extend the requirement that accountability agreements be put in place between all health service providers and their local LHIN. We request and we recommend to the committee and to the Ministry of Health that the Ministry of Health ensure that parallel language to the language I’ve just quoted is contained in the accountability agreements provided for in Bill 36.

I’d now like to ask Peter Lauwers to address our comments on part V of Bill 36 related to the limitations on the powers of LHINs and the minister.

Mr. Peter Lauwers: You can see from the brief that we’re particularly concerned about the language in clause

26(2)(f), which you’ll see on page 9 of the brief, and subsection 28(2), which says, “An order made by the minister ... shall not unjustifiably require a health service provider ... to provide a service that is contrary to the religion related to the organization.”

Some people have said that the word “unjustifiably” is too loose, making justification too easy. Our understanding of the word “unjustifiable” and the minister’s intent in bringing it in is that it relates to the Canadian Charter of Rights and Freedoms and the sense under that bill that decisions under Bill 36 would respect charter rights. The argument around that is that section 1, as you’ll see on the top of page 10, says, “The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it and is subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”

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The test that the court has set for this is called the Oakes test. It’s very clear: The limiting measures must be carefully designed or rationally connected to the objective, they must impair the right as little as possible, and their effects must not severely entrench on the right in question. That test is pretty clear. Courts understand it; administrators understand it as well. We say that it’s appropriate to include the language that we suggest on page 10, that “(2)(f) shall not unjustifiably, within the meaning of section 1 of the Canadian Charter of Rights and Freedoms, require a health service provider” to do this. The ministry accepts that this test is what is applicable. We are asking that the language make direct reference to the charter and that it be added for clarity. We understand that the minister is personally supportive of the proposed language and we commend it to you.

The Chair: Thank you very much for your presentation. You’ve used the 15 minutes.

YEE HONG CENTRE FOR GERIATRIC CARE

The Chair: The next presentation is from the Yee Hong Centre For Geriatric Care—Dr. Wong and Madam Wong, please. You’ve got 15 minutes total. Happy New Year. You can start any time you’re ready.

Dr. Joseph Wong: Thank you very much for giving us the opportunity to talk to you today. I’m Dr. Joseph Wong. I’m the founding chairman of Yee Hong. On my right is Florence Wong, who is not related. She is the CEO of the centre.

The Yee Hong Centre for Geriatric Care is the largest non-profit geriatric care centre providing services to Chinese Canadian seniors in Canada. It was founded by me and a lot of committed volunteers in 1994. The centre provides a continuum of services to Chinese Canadian and other seniors in the GTA through four long-term-care facilities, with a total of 805 nursing beds, close to 1,000 units of senior apartments and a wide range of community support services, including daycare centres. We

have medical services, as well as cancer and palliative care services.

While the first Yee Hong Centre was completed in 1994, I established a Yee Hong community wellness foundation in 1987 and started to rally support from the community and the provincial government to establish a comprehensive geriatric care centre offering language and culturally appropriate services to Canadians of Chinese descent.

I came back from the States after finishing my medical studies in 1976 and started to serve the downtown hospitals and nursing homes. At that time, I was often required to see patients in nursing homes, and that is where I met a lot of Canadians of Chinese descent. They suffered so much physical and emotional stress that many of them asked me to end their lives, because they didn't want to endure years of isolation, hopelessness and frustration. It was at that time that the idea of establishing a centre appropriate to the culture and language of Chinese Canadian seniors germinated.

Historically, health delivery in Ontario has been blind to the needs of culture and language. It took me more than three years, from 1987 to 1990, to convince the Ministry of Health and Long-Term Care that the needs of seniors of different cultural diversity in Ontario really do require special treatment. In 1990, the provincial government awarded 660 beds to different communities, of which the Chinese community got 80. We started the first centre in 1994. Subsequently, because the standard of service and excellence of service delivery to seniors of Chinese descent was so good, the ministry awarded Yee Hong Centre a total of 715 beds in 1999-2000. That is the single-largest allocation of nursing home beds in the history of the province.

The waiting list now for the four Yee Hong centres totals more than 1,000 people. Although we have less than 1% of the total beds in the province, our waiting list consists of more than 30% of the total waiting list of the whole province. That is why the service at Yee Hong attracts not only people of Chinese descent but other seniors who really require culturally appropriate services.

The Yee Hong Centre has been commended by the Canadian Council on Health Services Accreditation as a provider of best practices in multicultural services. The centre has achieved this recognition by devoting tremendous energy to developing and providing culturally and linguistically appropriate and compassionate care, not only to Chinese Canadian seniors but also to South Asian, Japanese, Filipino and Portuguese Canadian seniors. Throughout the years, the centre has worked with many cultural communities to plan, develop and provide senior services. With its opportunities and experience, the centre is able to understand the needs of various communities and the inadequacy of the current health and social services system in Ontario to respond to these special needs. It is therefore an obligation and a responsibility of the centre to review the proposed Bill 36 through the critical lens of a provider of culturally appropriate senior services, with the goal of improving

access to services for all cultural and language minority seniors in Ontario.

The Canadian Constitution recognizes the essence and nature of nation-building in this country. Multiculturalism and diversity is not only a policy; it is the character of the Canadian people and the most important and vital part of the Canadian fabric, which makes us unique in the world. This characteristic and trend is more obvious in this province than the rest of the country.

Bill 36 aims at enhancing access, accountability and integration of health services across the province. Given the diverse cultural and linguistic demographic makeup of Ontario, it is critical for the legislation to provide access to culturally and linguistically appropriate services as needed by our diverse community across the province, particularly in the GTA. To this end, we wish to address the following four issues raised by Bill 36 in this submission. I will be talking about the number one issue, regionalization and service utilization of cultural minority seniors, and my CEO, Florence Wong, will be talking about governance/accountability, funding and integration.

Because of the lack of culturally appropriate services in their communities, cultural minority seniors such as Chinese Canadians often have to seek such services outside of their areas of residence. Out of the 1,221 individuals on the waiting list for the four Yee Hong facilities, 645 reside outside of their areas. That means more than half of the waiting list of seniors for Yee Hong reside outside of the areas where our facilities are located. Some residents are as far away as Vancouver, Ottawa and Edmonton.

The need for culturally and linguistically appropriate services is not only evident in the long waiting list for Yee Hong services, it is also reflected in national survey research conducted by a professor at the University of Toronto in 2002. The survey aimed at examining the relationship between culture and health among older Chinese Canadians in this country. From the 2,272 respondents interviewed, over 45% identified health professionals who did not speak their language as the most common barrier in accessing health care services. The other common barriers related to professionals not understanding their culture, and programs not specialized for Chinese users.

Until such time as service providers in their regions are able to meet their needs, cultural minority communities will continue to access services outside of their regional catchment areas. Regionalization of health care services based on the utilization pattern and flow of users of acute care may not reflect the user flow of seniors for long-term-care facilities. Planning on a regional basis tends to focus on the needs of the population of the specific geographic boundary. The region may not take into consideration the needs of a specific cultural minority seniors' group that lives outside of the boundary. So there is a need for planning at the provincial level to ensure continuing access to services.

We have two recommendations in this area. The number one recommendation is that the legislation should be amended to specifically ensure that individuals are able

to access services that are culturally and linguistically appropriate. Second, the legislation should be amended to ensure that there is planning at the provincial level to ensure continued access to services that are culturally and linguistically appropriate.

Florence?

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Ms. Florence Wong: Recognizing the time constraints, how much more time do I have?

The Chair: About four minutes.

Ms. Wong: Okay. I'll address the balance of the three issues. I will first of all address governance/accountability. As community accountability is one of the legislative objectives of Bill 36, it is important to ensure that the governing bodies of LHINs—that is, the boards—reflect the diversity of the population they serve in terms of culture, language, gender and other demographic characteristics. Diversity of the boards could provide better linkages with a broader range of communities and enrich the experience of the board members to ensure that their decisions are relevant and effective. We therefore recommend that the legislation should be amended to specify the requirement for LHINs' boards of directors to reflect the diversity of the population they serve based on language, culture, gender and other grounds.

The next issue I want to address is about funding. While LHINs are empowered to provide funding to providers for services, there are no further details in the proposed legislation with respect to how funding will be allocated. Without any consistent funding formula, there is a risk that regional discrepancy in funding allocation for long-term-care services may lead to differences in standards of care and access to services. Without specific requirements for LHINs to take into consideration the needs of service users outside their catchment areas to access culturally appropriate services, these services may be at risk. We therefore have two recommendations in this area. The first one is that to ensure equity in services and minimum standards of care, the legislation should ensure that the provincial funding formula currently in place for all long-term-care facilities continues. Second, the legislation should also be amended to include criteria for funding allocation so that special-needs populations, such as those for cultural- and linguistic-specific services, are reflected.

Finally, on the subject of integration, currently there are no criteria specified in the legislation for integration decisions or orders by LHINs or by the minister other than that they are not to contradict the integrated health services plan and accountability agreement with the ministry. In the absence of clear criteria, there is a risk that integration decisions may negatively impact on access to culturally and linguistically appropriate services. Culturally appropriate services are developed through time commitment and resources by the provider. Consumers choose these services after the provider has proven its credibility and accountability. We therefore recommend that the legislation should be amended to provide for criteria regarding issuing integration deci-

sions or orders taking into account consumer choice for culturally and linguistically appropriate services as well as quality of and access to the services.

We thank you for the time given to us. We have a written submission, which has been distributed.

The Chair: Thank you. We have a minute. Madame Martel, do you want to use one minute, please?

Ms. Martel: Thank you very much for your presentation this morning. You have a broad range of services, as you've indicated. I would assume that they cut across the LHIN boundaries and that your concern would be not only with respect to ensuring that the level and the quality of service is maintained but that that service be culturally and linguistically appropriate. Right now, there isn't a guarantee of how all of that will happen, of course, because you'll be dealing with different LHINs. How do you see that each LHIN should be dealing with those matters to ensure that the high quality of service that you provide, which is linguistically and culturally appropriate, is able to continue to be provided?

Ms. Wong: We don't think that each LHIN could do it on their own, because minority groups tend to go to the place where they can find culturally appropriate service, so they do cross LHINs. I think it is necessary for LHINs to work together on a regional or provincial level to plan for services for cultural minorities.

Dr. Wong: Yee Hong serves a lot of people outside of the catchment area. As we said, we have a lot of Chinese Canadian seniors coming from northern Ontario to our four centres in the GTA. So it is very important for the legislation to require LHINs to co-operate on this area. We really would like to see the legislation not leave the discretion to the LHINs but that it be required for the LHINs to work on this area. We understand that each individual LHIN would not be able to establish culturally appropriate services in that particular area, because it should be a concentration of services so that culturally and linguistically appropriate services could be provided at a very reasonable cost to the constituents.

The Chair: Thank you. Ms. Witmer, please.

Mrs. Witmer: Thank you very much for an excellent presentation. We do appreciate your recommendations. When you talk about legislation, you talk about the need for it, obviously, to take into consideration culturally and linguistically appropriate services. Do you have a concern that some of these services could disappear under the LHINs?

Dr. Wong: We are very concerned that present health care access does not reflect the importance of culturally and linguistically appropriate services. A lot of minorities in Ontario still do not have access to culturally appropriate services. Yee Hong has been trying to provide services not only to Chinese Canadians but, as I said, to Filipino Canadians, of which there is a big concentration in Mississauga. That is why, in the Mississauga Yee Hong Centres, we have a wing specifically to serve those cultural and language needs of Filipino seniors. In Markham, we have a whole floor dedicated to serving Canadians of south Asian descent. Also, in our newer centre

at Scarborough-Finch, we have a wing for Japanese Canadian seniors. We also serve a small number of Portuguese Canadians in our Mississauga area because of the big concentration of Portuguese Canadian seniors in Peel region. So we are looking for ways to improve health care access from different health care communities. We have been successful to a certain degree, but I really hope that the legislation should provide a very clear guideline to all LHINs so that this particular very important aspect of senior long-term-care services should be respected.

The Chair: So everybody can ask a question, we'll just go over the time a little bit. Ms. Wynne.

Ms. Wynne: Just very quickly. The level of specificity that you're talking about, I understand, is not in the legislation, but the planning process is to include community engagement and is to deal with the issues of each of the communities involved in the LHINs. To my mind, that's where these concerns get taken up. I take your point about the boards representing the demographics of the area. I think that's a very interesting suggestion. Could you just talk briefly about the community engagement process and what you think needs to be explicit that would ensure that your concerns were taken care of?

Dr. Wong: Very often, many of these cultural communities are newer Canadian communities, and a lot of the people inside the community, including so-called leaders of the communities, have not been able to use effectively the language and other aspects to provide access for the seniors within their community. So I believe that LHINs should be required to actively seek out these needs rather than waiting passively for people to come to them. A good example is the Portuguese community. A good example is other communities that we are serving: south Asians and others. The Filipino communities particularly have not been in this country for too long, and they often lack the connections to access health care authorities giving them the funding or other requirements so that they could provide access to their own seniors. Yee Hong is a good example, but I hope it would be enshrined in the legislation so that LHINs should be able to seek out services that are appropriate for various cultural communities, since they really make up a big part of southern Ontario.

Ms. Wynne: Would you put that in section 16, in that community engagement section? Just a quick yes or no.

Dr. Wong: Yes, I would.

The Chair: Thank you very much, Dr. Wong and Ms. Wong.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 2.ON

The Chair: We'll move to the next presentation, from the Service Employees International Union, Local 2.on, Toronto, Shalom Schachter. Good morning.

Rabbi Shalom Schachter: Good morning. Sorry that Nathan Kelly was not able to join us this morning.

I represent Service Employees International Union Local 2. We have 7,000 members in Ontario, including

security officers at local hospitals in Toronto. For our oral presentation, I'm going to highlight sections of our written submission. Some of the recommendations are interspersed throughout the written submission, and the remainder of the recommendations are at the end of our brief.

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On page 2, we indicate that Bill 36, as it is presently drafted, is not local, not comprehensive of health nor sufficiently comprehensive of systems integration. The first point we deal with at the bottom of page 3 is in terms of the absence of local accountability.

You've heard many of the criticisms from others about the absence of "local" in the legislation. What we bring to this committee today is the statement by the minister when he introduced his estimates at the standing committee on September 27. The minister stated that LHINs are going to be "community-based government, by and for the community." Unfortunately, these sentiments are not reflected in the bill. This failure of the legislation to live up to the minister's undertakings that were given at the commencement of his presentation to the committee and therefore form one of the presumed conditions upon which his estimates were approved, is particularly troublesome. We conclude our submission on this part on page 5, indicating that the absence of locally elected LHIN boards leaves the decision-making in the hands of provincially appointed bureaucrats, giving credence to the criticism south of the border that our health care system is Stalinist-light.

In terms of the interest in community engagement, a necessary condition for that is that the LHIN board members be elected by the adult population served and by the adoption of recommendation A at the back of our submission concerning CCAC governance.

The second deficiency is the absence of crucial elements of health from the bill. Again, you've heard from a number of presenters. At the bottom of page 6, we indicate that we urge that these gaps be reviewed; that after the bill receives royal assent, there should be a wholesale review of the legislation 18 months later to see how we can best incorporate those gaps; and that paragraphs 10 and 11 of subsection 2(2) should be immediately amended so that those health care providers are covered whether they provide services on a for-profit basis or a not-for-profit basis. Right now, only the not-for-profit health service providers are covered by the legislation.

In terms of the third deficiency, systems integration not being sufficiently comprehensive, that starts at page 7 of our submission. I'll direct you to page 8. There is a widespread belief that one of the unstated objectives of the government is to increase the role of the private sector in the delivery of health care. This objective was held by the Harris government and is manifest in the allocation of the additional long-term-care beds that were issued under the RFP process. On a net-change basis, all of the new beds were allocated to for-profit nursing homes. In 2000, prior to the expansion, there were a total of 55,784 long-term-care beds, of which 30,899, or

55.4%, were in nursing homes. Six years later, there are now 69,580 long-term-care beds, of which 46,105, or 66.3%, are in nursing homes, an absolute increase in this number of almost 50%, with a shrinkage both absolutely and proportionately in terms of other types of long-term-care beds.

On page 9, we indicate that the McGuinty government has already increased the role of the private sector through its alternative financing program for hospitals. You've heard from OANHSS and today from the city of Toronto that there is no valid reason for the exemption of for-profit health service providers from the scope of authority of subsection 28(1) of the bill, and we ask that that section be broadened to include for-profit providers.

Another area of missing systems integration is in the area of labour adjustment—at this point, I'll direct your attention to page 10 of our submission—in terms of the inadequate scope of the Public Sector Labour Relations Transition Act, otherwise known as PSLRTA. There is a typographical error on page 10 and again in the references on page 11. Where you see subsection 31(3), it should refer to subsection 32(3). Please make that correction. I apologize for that error. That section excludes successor employers who are not health care providers and where the health sector is not the primary recipient of their services.

Our union represents security officers at many hospitals in Toronto. The environment where these services are provided has special requirements. Not only are all persons in the province invited to come onto the premises of hospitals, but hospitals, unlike other providers of services such as retail malls, do not have the right to deny access to persons deemed socially undesirable.

Special care must be taken by security officers in the hospital environment. The SARS outbreak of a few years ago brought home the importance of effective entry protocols to such facilities. The current concern over the outbreak of a pandemic demonstrates the need to maintain and improve such protocols.

These security officers regularly interact with psychiatric patients, as well as others who may become aggressive or even violent. The role of the security officer in this environment is not only to protect the safety of the public and the property of the hospital, but also the safety and health of the person who is the subject of the security officer's attention and to support that person's therapeutic rehabilitation. In short, the skills and abilities of security officers in the hospital environment are not interchangeable with those working outside of health care.

Section 32(3) would mean that, if the security service is contracted out to a provider who is larger and who's not primarily operating in the health care environment, existing security officers will be prejudiced in the following way: Their employment may not have to be continued; even if their employment is continued, their wages and benefits can be reduced; and even if their wages and benefits aren't reduced, the new employer doesn't have to recognize the right of these employees to

be unionized and represented by the union of their choice.

In cases where section 32(3) is not applicable, the actions listed above cannot occur before a vote is taken.

Going on to page 12, aside from the prejudice to the health care system that would result from a loss of experienced security personnel is the infringement on democracy and the absence of a secret ballot on the making of these important decisions. Later this morning, a change is going to take place in our national government which was accomplished peacefully through the means of a secret ballot. It is unthinkable that in this province, given the importance of health care to Ontarians and the crucial role of human resources in the delivery of that care, any workers involved in health care would have their union representation rights removed without a secret ballot. We urge this committee to arrange for the deletion of section 32(3).

Our presentation then continues, indicating at the bottom of page 14 that there are other recommendations on democracy and integration at the back of our submissions. Finally, other deficiencies in the bill are set out on page 15. There are deficiencies in the accountability of the LHINs, deficiencies in the accountability of the minister and in the absence of adequate transparency in decision-making.

There should be an amendment requiring that all decisions of the LHINs, the minister and the Lieutenant Governor in Council made under this act be consistent with the purposes set out in the preamble and section 5 of the act. Every decision taken must set out the key facts demonstrating that it meets such purposes.

Much of the public concern surrounding the introduction of the LHINs is the uncertainty over the values and approaches that will guide the integration decisions. The minister has attempted to discount many of these concerns, stating that there's nothing in the legislation that gives a basis for that. In fact, there is, and that is section 14, dealing with the adoption of a provincial strategic plan. The committee should recommend that no strategic plan shall take effect unless it is ratified by a motion in the Legislature.

Going on to page 17, in terms of the shifting of public resources to for-profit providers, the bill should be amended to require that any decision transferring delivery of a service from a not-for-profit to a for-profit provider require the publication of the data that demonstrate that the for-profit provider will have a better health care outcome for no more than the same cost, or at least as good an outcome as the not-for-profit deliverer and a lower cost. Similarly, the extension of the request for proposal or any other competitive bidding system should not occur without documentation that it results in a better quality at no increase in cost, or a lower cost with no decrease in quality. Finally, any future RFPs should require that the winner employ the employees of the loser and that any issue of representation rights be resolved under PSLRTA.

At this point, if there's time, I'm going to answer any questions.

The Chair: There is only one minute. I'll go to Ms. Wynne.

1000

Ms. Wynne: Sure. Thank you very much for your presentation. I guess the overarching question I'd like to ask you is whether you believe that there's a need in this province for an increase in coordination of care, because that's really what this legislation is about. We've heard a number of times from SEIU across the province. This is our fifth day of hearings, and we've heard every day from one local or another of SEIU. I just need to hear whether you believe that it's a good thing that we would be trying to coordinate and plan. I'm curious specifically about your concern about the provincial plan. Is there not a need for a provincial plan into which the LHIN planning would fit?

Rabbi Schachter: Yes, we do believe in the need for integration. This submission contains some recommendations to improve and enhance integration. In terms of the other hat that I wear, while I'm a member of SEIU, I'm an employee of the Ontario Nurses' Association. You've heard from ONA that for the past 10 years we've been supporting integration. The problem is that this model doesn't do it right, and the provincial strategic plan is going to contain very crucial elements. It may contain issues in terms of how local services are going to be delivered and whether there has to be travel. It may contain issues in terms of whether there's going to be a bias in favour of for-profit providers. These things, that are maybe in the provincial strategic plan, should be the subject of debate in the Legislature, and there should have to be a motion supporting that provincial strategic plan before it's implemented, and then before the LHINs accountability agreements and integration decisions that are based on the provincial strategic plan get adopted.

The Chair: Thank you very much for your presentation, sir.

ONTARIO HOSPITAL ASSOCIATION

The Chair: The next presentation is from the Ontario Hospital Association. If you could start when you're ready. We have 15 minutes in total, please.

Ms. Hilary Short: Good morning, I'm Hilary Short and I'm president and CEO of the Ontario Hospital Association. Joining me is Mark Rochon, chair of the advocacy committee of the OHA's board of directors, and president and CEO of the Toronto Rehabilitation Institute.

We are pleased to have this opportunity to comment on Bill 36, the Local Health System Integration Act, 2006. Let me begin by saying that the OHA supports the aims and the principles of Bill 36. We believe that local health integration networks have the potential to improve the integration of health care services while meeting the unique needs and priorities of communities across Ontario.

OHA has consistently endorsed the made-in-Ontario model of integration that the government has adopted.

This model recognizes the value of voluntary governance and the importance of local decision-making among interdependent organizations such as community-based health providers and hospitals. Since November 2004, the OHA's board of directors, advocacy committee and staff have worked hard to provide constructive advice and support to the government as its integration plan moves from the theoretical to the practical. In concert with other stakeholders, the OHA developed a set of principles meant to guide and facilitate the development and implementation of LHINs. Many of these principles were subsequently adopted by the Ministry of Health and Long-Term Care.

In February 2005, we published a policy paper that provided concrete recommendations about how LHINs could be constructed and could be run most effectively. We hosted a conference on LHINs that attracted hospital leaders, doctors, nurses, decision-makers and stakeholders from across the broader health care sector. We plan to continue offering legislators and the government whatever assistance we can because we want LHINs to be successful.

Today we're pleased to offer this committee our comments on Bill 36. We strongly believe that our proposed amendments to Bill 36 are needed to improve and strengthen the bill to the benefit of those who use and work in Ontario's health care system. While our recommendations are set out in detail in our written submission, I'm going to ask Mark to speak to some of the more important aspects of the submission.

Mr. Mark Rochon: Thank you, Hilary, Mr. Chair and committee members. Our review of Bill 36 was guided by a number of considerations: First, we wanted to ensure that LHINs had sufficient authority to do their job. Second, we felt it was important to examine what, if any, process LHINs would be required to follow when consulting with the community and health stakeholders, developing plans and making decisions. Finally, we looked at whether the provisions of Bill 36 require LHINs to operate in the open, accountable and transparent manner that Ontarians would expect.

We have identified a number of ways in which the bill could be significantly improved, and with input from our members have developed some recommendations in that regard. I'll now review some of these recommendations.

First, I would like to speak to Bill 36's treatment of hospital foundations. Our members are concerned with proposed amendments to the Public Hospitals Act that would give LHINs the ability to receive the financial reports of foundations. Given that foundations are independent corporations that do not fall within the scope of LHINs, these amendments seem out of place in the context of the broader bill. This has sparked concerns among hospitals, foundations and donors about why Bill 36 would give LHINs an interest in hospital foundation matters. We are concerned that any perception of donated funds possibly being directed by the LHIN for unintended purposes could severely damage foundations' fundraising efforts. As you know, these fundraising

efforts make hospital capital renewal projects possible. Any reduction in donations would make it more difficult, if not impossible, for hospitals and the province to move ahead with these needed capital projects. Given this, we strongly recommend that this provision be deleted.

One of the most important aspects of the LHINs' mandate is the development of an integrated health services plan for its local area. This plan will form the basis of most LHIN decisions, including those respecting service integration. Although Bill 36 requires LHINs to consult with the community when developing their plan, it does not define "community," nor indicate what the nature and extent of the community engagement must be. In the absence of a specific definition of "community," it is possible that hospitals and other health care providers, those most responsible for providing most local health services, would not be consulted prior to or during the development of this plan. As this consultative process will be critical in determining what programs and services will be offered within a community, we believe that Bill 36 should be amended to provide an explicit consultation process that includes local health care providers.

The OHA also looked at the basis upon which integration decisions and orders will be made. In the interests of ensuring evidence-based decision-making, we recommend setting out objective criteria that must be considered prior to issuing an integration decision or order. We believe that, at a minimum, decisions must be evidence-based and take into account factors affecting patient care, such as choice, quality and access. Bill 36 obligates LHINs and the minister to consider the public interest when issuing integration decisions or orders. However, the bill leaves the term "public interest" undefined. We believe that the bill should be amended to include a definition of "public interest" similar to that found in either the Public Hospitals Act or the Commitment to the Future of Medicare Act. This would ensure that patient care and community needs are given due consideration.

One of the most important issues for the OHA and its members with respect to Bill 36 is the need for due process. We believe that Bill 36 should provide for due process prior to the issuing of integration decisions or orders. As currently drafted, Bill 36 permits LHINs and the minister to issue integration decisions or orders without having first provided affected providers with an opportunity to be heard on the merits of the specific proposed decision. Although providers have 30 days to request reconsideration of an integration decision or order, there's no requirement for LHINs to consider the submission of the affected party, nor does the bill provide for any third-party appeal process. Given the potential impact that integration decisions and orders may have on communities, facilities and stakeholders, we believe that those most affected should have an opportunity to be apprised of and provide input on a proposed integration decision or order, particularly if there is no avenue for appeal.

We therefore request that Bill 36 be amended to provide for some minimum procedural standards prior to

the issuance of an integration decision or order. This might include notice of an intended decision to the affected provider, the opportunity for the provider to provide comments, and a requirement that the LHIN or minister take into account the submissions made.

These are a few of the suggestions that we believe will improve and strengthen Bill 36. Further details and additional recommendations are set out in our written submission.

I'll now turn to Hilary for some concluding remarks.

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Ms. Short: Let me close the way I began. The Ontario Hospital Association supports the aims and principles of Bill 36. We stand squarely behind the government's plan for health system transformation and the establishment of LHINs, and we believe that our proposed amendments to Bill 36 will help make LHINs a success. Providing constructive input over the last year, today and in the weeks and months ahead with respect to LHINs is part of that effort.

Once again, thank you for the opportunity to appear before you today, and we'd be pleased to take any questions.

The Chair: We have at least a minute each. Ms. Witmer, please.

Mrs. Witmer: Thank you very much for your presentation. The question I have for you is, how does the power of the Minister of Health differ in this legislation? It appears at first blush that there's more power here for the minister than there was under the Health Services Restructuring Commission. What additional powers does the minister have in accordance with this legislation?

Mr. Rochon: We see the powers as somewhat similar. In our view, the powers that exist under the Public Hospitals Act that the minister now has would be similar to those that would exist once the legislation is considered and its final form proclaimed.

Mrs. Witmer: We've heard from some people that they think the power of the minister is more far-reaching in this legislation.

Mr. Rochon: We don't see it that way.

Mrs. Witmer: Are your hospitals at all concerned about section 30, the foundations, where if a service or program is shifted to another hospital, the money in the foundation would follow that movement?

Mr. Rochon: That's why we're recommending the changes that we're suggesting here in terms of reporting of foundation issues.

Mrs. Witmer: Right, but you haven't made any reference to section 30, I don't believe.

Mr. Rochon: Correct.

Mrs. Witmer: Do you have any recommendations for amendments there?

Mr. Rochon: I don't believe we do.

Ms. Short: We don't at this point. I guess we would consider that somewhat more like an implementation issue. Under the restructuring commission, the foundations did find ways to merge and create different organizations when the commission ordered mergers. So

I think the foundations have found ways to merge successfully.

The Chair: Thank you very much. Ms. Martel, please.

Ms. Martel: Thank you for being here this morning. I wanted to go to your proposed amendments for sections 26 and 28, because you made a point to say that there really isn't due process either with respect to an integration decision or an order by the minister.

If I read the amendment right, you didn't go so far as to make reference to a third-party dispute mechanism, because for some people it seems a bit unrealistic to go back to the same body that already made a negative decision and hope for a successful reconsideration. You talked about a third-party process. It's not in the amendment. What's your view then on some kind of third-party appeal mechanism?

Mr. Rochon: We're not recommending a third-party appeal mechanism, in part because we believe that the body that is accountable for the execution of the decision and for making the decision ought to hold that decision close to their own processes. In our view, ensuring that there is an opportunity for hospitals to recommend on an intended decision on the part of the LHIN would make more sense than continuing to deal with appeal mechanisms.

Ms. Short: We should add that this was the subject of quite intense discussion and debate, obviously, on the question of whether there would be a third-party appeal mechanism.

Yes, there was another concern too that the hospitals really—because we support this bill, there is sort of a risk. As Mark says, there's also the further risk that it doesn't have sufficient authority to carry out its decision and it would get tied up, and any decision could be held up for a long period of time. That was the other thing, but it was something we thought about very carefully. We decided that we felt having clear criteria to make these decisions, having decisions evidence-based and making sure that there was a notice would be better than a third-party appeal process.

Ms. Martel: What about the notice to the public? Right now, all of this goes between the service provider and the government, and there's no role for the public when they want to express concerns about the loss of a service.

Ms. Short: I think we are suggesting that that notice be public.

Mr. Rochon: That's a reasonable perspective. This should not just be between providers and LHINs.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thank you very much for being here. I wanted to just follow up on your concern about the local health care providers and community engagement. If this bill passes, there will be a process whereby the specifics around community engagement will be articulated in regulation, and people will have the ability to have input into those regulations.

Are you suggesting that subsection 16(1), which says, "A local health integration network shall engage the

community of persons and entities involved with the local health system about that system on an ongoing basis" etc., is not specific enough? Because it seems to me that provides for consultation with the local health care providers on an ongoing basis.

Ms. Short: We're suggesting that it be made more specific in the legislation and not left to regulation. We see the community engagement process, particularly, let's say, in Metropolitan Toronto, in the GTA, as pretty complex. We think more should be made explicit in the legislation, since it's something new and something that we would prefer to see more of and not just all left to the regulations.

Ms. Wynne: I haven't looked at your specific recommendations but if there's language—because, as I say, that section seems to have provision for the health care community to be involved, so I thought it was adequate. But if you've got language, maybe you could let us see that in the written—

Mr. Rochon: Yes, we have—

Ms. Short: The language is in the written submission. We have precise language suggested in the submission.

Ms. Wynne: Okay. Thank you.

The Chair: Thank you for your presentation.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair: The next presentation is from the Registered Nurses' Association of Ontario. You can have a seat. There are 15 minutes for the total presentation and potential questions and answers from the members. Whenever you are ready, you can start.

Dr. Mary Ferguson-Paré: Thank you for the opportunity to address the committee on this very important piece of legislation. My name is Mary Ferguson-Paré. I'm the president-elect of the Registered Nurses' Association of Ontario.

From the outset, I want to reiterate our association's support for the government's health care transformation agenda and our support for the role that LHINs can play in that agenda. Medicare will be strengthened by reforms that improve population health and improve access to care by the right provider, at the right time and in the right place. However, we have some profound concerns about this proposed legislation. In my remarks, I will provide you with an overview of how we believe these concerns can be addressed. For more details, please refer to our submission, which I believe you have in front of you.

We understand that the government's objective for system transformation is to serve Ontarians better. This bill will not achieve that objective without an explicit commitment to a single-tier health care system and to expanded not-for-profit delivery. Instead, this legislation will result in an erosion of medicare and lower quality health care services for Ontarians.

We remain puzzled and gravely concerned by the McGuinty government's choice not to make the Canada

Health Act a centrepiece of the LHINs legislation. We recommend that both the Commitment to the Future of Medicare Act and the Canada Health Act serve as central themes to both the preamble and the objects of the bill.

We are similarly concerned that there are no provisions in the bill which encourage, let alone require, LHINs, the minister or cabinet to preserve or expand public not-for-profit delivery of health care services. The evidence is clear: A single-payer system of not-for-profit health care delivery results in higher quality care at lower cost.

We believe that three amendments to Bill 36 would provide LHINs with the tools they need to support and expand not-for-profit delivery. The first is to give not-for-profit providers the first right of refusal. Only if not-for-profit providers are unwilling or unable to accept the transfer of health services should transfer to for-profit providers occur.

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The second is to ensure that integration between a for-profit provider and a not-for-profit provider would only be allowed if the resulting health service provider operates on a not-for-profit basis.

The third is to provide the minister with identical powers with respect to both for-profit and not-for-profit providers.

Concerns have been expressed by health care workers and a range of Ontarians, including seniors, that this bill will facilitate an expansion of competitive bidding in health care. Such an expansion would be expensive, inefficient and lead to deteriorating health outcomes.

We have been assured by senior government officials that there is no intention to expand competitive bidding beyond the home care sector. As any legislation passed will continue beyond the current government and minister, it is essential that this policy decision be enshrined in the proposed legislation.

We recommend an amendment to the bill that prohibits competitive bidding as a way for LHINs to allocate funds among health service providers. This would address these concerns.

Bill 36 provides for contracting out of both clinical and non-clinical support services. As nurses who are at the bedside 24 hours a day, we understand the importance of every member of the health care team in ensuring patient safety and contributing to healthy work environments. Housekeeping and nutrition services are two such services that have a profound impact on patient outcomes, including infection control and nutrition support.

Contracting out of these services results in workers who are disengaged from the important work they do and demoralized by low wages and lack of job security. High employee turnover disrupts care, as does transitory employment where workers do not understand the culture and values of the organization they are working in.

When these services that include direct patient contact are contracted out, there are two choices: Either patient care and patient environment suffer or nurses are taken

away from their central clinical work to provide these services. If nurses pick up the slack, the additional workloads for overburdened nursing staff will increase burnout and injury rates, hence creating shortages. This will worsen patient outcomes.

The following two amendments to the legislation would address these concerns: Prohibit LHINs from facilitating or ordering contracting out of any hospital or residential care facility service that provides direct clinical or non-clinical patient services. Secondly, prohibit cabinet from ordering contracting out of any hospital services that provide non-clinical patient services.

I now want to turn to the issue of health human resources. We cannot forget that transforming the health care system means transforming the way people work and where they work. Given that physicians are outside the sphere of LHINs, this legislation will, to a large extent, mean transforming where and how nurses work.

We cannot forget the characteristics of the nursing workforce. The first is that the average age of registered nurses working in Ontario is 45 years. More than 50% of them will be eligible to retire over the next 10 years. More than 60% of registered nurses work in hospitals. We have to compete internationally and interprovincially for this generation of nurses. We also have to compete with a myriad of other professions and occupations for the next generation of nurses.

This legislation must address the retention and recruitment issues that it will provoke. It should be guided by the following principles: The need to maintain the acute care nursing workforce as an essential part of the system; the need to equalize remuneration and working conditions across sectors; the need for quality work environments across sectors; and the need for professional development and training to move across sectors.

I thank the committee for your attention. We look forward to working with you to ensure that this legislation meets the government's objectives of health care transformation.

The Chair: Thank you. Madam Martel, one minute each, please.

Ms. Martel: Thank you for your presentation today. Congratulations, president-elect. I'm sure you'll enjoy your time.

I want to thank you very much for making a point that if the government is serious when it says that competitive bidding is not going to be used as the model for LHINs to acquire services, that should absolutely be in the legislation. Also, I thought it was important that RNAO has pointed out that your position on outsourcing is very clear.

You've specifically said that the bill should prohibit cabinet from ordering contracting out of any hospital services that provide non-clinical patient services. You've talked about cleaning and infection control. The problem is that "non-clinical" is not defined in the legislation. So while we all think we're talking about the same thing, it's not clear to me that when this process starts

down the road, "non-clinical services" is not going to have a broader definition. Do you have some other suggestions about how we get at "non-clinical," or do we just say we should be deleting that whole section altogether given the lack of clarity?

Ms. Sheila Block: I think we have a concern. If you look at recommendation 4, we talk about both the ability for LHINs to issue decisions and the ability of cabinet. We share that concern about the definition of non-clinical services. What we are looking for is a definition of both clinical and non-clinical services that have direct patient contact, so that moves from unit clerks to housekeeping to dietary to actual delivery of meals. Those are the kinds of patient contact we're concerned about contracting out and it doesn't include back office kinds of operations, to be clear.

The Chair: Thank you. Mr. Ramal.

Mr. Khalil Ramal (London-Fanshawe): Thank you for your presentation. You touched on so many different elements, but I want to go back first to when you talked about two-tier health care. Do you not think the minister, when he opened the session of this committee, was clear in terms of keeping health care in the public domain? He's against any hospital closure and against two-tier health care. It was a very comfortable zone for you and for many health care providers in Ontario.

The second question would be, I don't understand what you meant by the same power for both for-profit and not-for-profit.

The third part of my question is about the policy. You said you spoke to the ministry and the minister's staff and you got an assurance about no expansion of competitive bidding. You mentioned later on, "Well, if the government changes and if the minister changes, what's going to happen to us?"

I want to tell you that we cannot control this issue beyond our government. As you know, any minister or any government, when they come to power, has a right in law to change whatever rules and laws have been implemented before, and can change it to the way it suits the direction of their government.

Those are my questions, if you wish to answer those.

Dr. Ferguson-Paré: Perhaps to begin with, we are looking within the legislation for a commitment to the Canada Health Act and the Commitment to the Future of Medicare Act, that it would actually reference that in the legislation to ensure that that commitment is enshrined there.

Similarly, we are aware that of course different governments have different perspectives, strategies, plans. We believe since this government is presenting this bill and is not interested in expanding contracting out, we would like that to be enshrined within this bill, so that the legislation would be clear on that and it would carry forward to future governments.

Lastly, with regard to the same powers for for-profit and not-for-profit, those powers would include transfer, amalgamation. Presently, the minister has the power to determine those things in not-for-profit, and we would be

asking for the same powers in terms of for-profit services. Perhaps Sheila could expand on that.

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Ms. Block: Yes. We're looking at section 28 of the bill, and that is the minister's powers. As Ms. Ferguson-Paré said, we are looking for parallel powers, both for-profit and not-for-profit providers, because we feel otherwise it will bias against not-for-profit providers and facilitate an expansion of the for-profit sector.

Mrs. Witmer: In looking at your recommendation, I see that you've expressed some concern about the local control and autonomy of the LHIN boards and the fact that people can be, I guess, recalled at the pleasure of the minister and cabinet. What is your opinion as to them being selected by cabinet and approved by cabinet for this position? We've had somebody come in this morning and indicate that if this is indeed the case, they really do not represent their community, and perhaps there needs to be another selection method for the LHINs board.

Ms. Block: I think we both have some concerns about an order-in-council appointment method and some sympathy and understanding for it, so we believe that that should really be counterbalanced by our recommendations, in terms of fixed terms and other issues, to maintain the independence of those boards.

Mrs. Witmer: Okay. So you don't have a concern about cultural or linguistic representation on these boards.

Ms. Block: Our hope is that the order-in-council appointment process will provide that these boards are representative, and we think there will be the usual kinds of political pressures to ensure that they are representative. So far, in terms of the appointment process that we're aware of, that seems to be taken into account.

The Chair: Thank you very much for your presentation.

ST. JOSEPH'S HEALTHCARE HAMILTON HAMILTON HEALTH SCIENCES

The Chair: The next presentation is from St. Joseph's Healthcare Hamilton and Hamilton Health Sciences, Dr. Kevin Smith and Murray Martin. Good morning. Gentlemen, you have 15 minutes in total for your presentation and potential questions. Thank you.

Dr. Kevin Smith: Thank you very much for the opportunity. My name is Kevin Smith. I'm here with my colleague from Hamilton Health Sciences, Murray Martin. I'm very pleased to have an opportunity to talk to your group this morning and the opportunity for consultation around this important legislation.

Perhaps a bit of where we've come from: The Hamilton area hospital, St. Joseph's Healthcare and Hamilton Health Sciences, supports an area of over 1.5 million Ontarians from LHIN 4, now known as the Hamilton-Niagara-Haldimand-Brant and beyond LHIN, with a combined budget of almost \$1.2 billion, which is obviously a very large fiscal investment. We also have the good fortune of being part of an academic health science centre affiliated with McMaster University and

Mohawk College. The whole role and relationship of health science centres within LHINs will be an important part of our discussion. I'll just refer you to the document as it stands around our campuses. Collectively, our corporations operate 10 sites throughout our region.

First, let me start with a commentary on the widespread support for local health integration that our region enjoys, that our boards represent, and some observations we'd like to share with you. In our opinion, it's extremely important to explicitly recognize and respect the mission and values of denominational hospitals in legislation, and I know that there has been some discussion at these tables previously. We certainly support that. Beyond principle perhaps, in operations the issue of forced mergers have rarely been successes in hospitals, and I think there are many examples of that. The opportunity of appropriate merger or dissolution of a corporation is a different approach that we certainly would endorse.

Legislation should clearly identify that LHINs do not have an academic health science centre. It should be explicit around those that do have health science centres what our relationship must be between the other. I believe there are now five academic health science centres, so the remaining nine LHINs in our province.

Similarly, a theme you've heard a lot about—and we would certainly also support that—is the importance of a dispute resolution and appeal mechanism, an important part of modifying this legislation and an essential component to due process and natural justice.

Perhaps a word about some of the positives that the emergence of LHINs have shown for our region so far, and hopefully a strong commentary on the success of collaboration in our region: As I mentioned, we very much support the aims and principles of health system integration, and as a result of that, a number of things have happened in our LHIN in our region, which include integrated vice-president roles across our hospitals with emergency services, mental health, support services, children's services, cardiac services, cancer services and beyond. So in our \$1.2-billion collective entities, we actually have one leader within those entities to represent each of those important programs. As an academic health science centre, within those programs we reach well beyond Hamilton but into our broader LHIN, and in fact outside the LHIN as well.

Another important initiative that's been very beneficial so far, and that I think will show even greater promise in the future, is a LHIN-wide chief information officer. We have done so in a model with all 12 hospitals, and come forward now with our LHIN office, with a single individual speaking on all our behalves in terms of building an integrated information system for Ontarians.

Certainly the advent of the LHIN or the evolution of LHINs has allowed extensive collaboration on systems planning and recruitment and retention, which Ms. Ferguson-Paré mentioned previously. We do, however, have a number of suggestions for improvement.

At this point I'd like to turn it over to my colleague, Murray Martin, who will speak to you.

Mr. Murray Martin: In terms of the comments from the previous group, we support the notion, and I'm sure everyone else does, that the board members be selected from the community's pool of skilled persons. We would never want to see the notion of moving to elected boards, as that has not proven to be very effective in other jurisdictions. But certainly the real key of the LHINs is going to be what that selection process is.

There are obviously many issues that actually need to be contained within the regulations, and it's likely the issues that will come into regulations that perhaps are of greatest concern. In terms of how hospitals negotiate accountability agreements with the LHINs is going to be terribly important to us, so there is a sense that there should be some reflection of what that process may look like in the legislation.

Next, providing an explicit consultation process on the integrated health service plans; in other words, spelling out at least some parameters as to how the creation of that plan is actually to take place, because that is the document that's going to be the road map for future health service delivery in the community. How we actually arrive at that and how we actually participate in that process is very important to us.

Some other issues that need further clarification—and again, recognizing that a lot of these will likely come out in regulations—are things like the extent, manner and timing of funding responsibilities. We know that we are going to move to a totally different funding model which, as you can appreciate, does scare people as to what that will mean for their individual institutions.

The issue of hospital accountability agreements: We're actually now into our first year of these new agreements. How will the sign-backs actually work with the LHIN? Will the Ministry of Health totally be out of the process? Is there an ability to have an appeal process to the ministry? Again, maybe getting into more of the details.

Another issue is really the silence related to the relationship with our physicians. That is something that I think needs to be looked at within the context of LHINs. What will this mean as it relates even to our legal relationship with our physician groups?

Kevin mentioned that we are academic health science centres. We actually do believe that within the context of LHINs there needs to be some specific reference to an association of every LHIN with an academic health science centre, as the reality is that there are 14 LHINs and there are academic health sciences centres in only about half of them. So those that don't have an academic centre should have a formal affiliation.

Reference was made in the previous presentation as to how it applies to the private sector. Obviously, we want to keep a fair and common system in place—certainly an implication for facilities with provincial programs for major teaching hospitals. People want to know how we will be assured that these provincial programs carry on.

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There is need for a specific reference to an appeal mechanism for a variety of aspects of the legislation, and

I'm sure you've heard that from many others. We certainly feel that is very important, the criteria for decisions and orders in terms of how this will actually work. Kevin mentioned the denominational safeguards required. There are question marks around the labour relations implications and, obviously, questions about a lot of the issues that are not within the LHINs, such as academic and especially hospital roles, physicians and provincial programs.

Finally, we all know that working effectively and efficiently together is an attitude, and it's about relationships. One of the things that we've noticed in our LHIN area, frankly, for people who have been in our community a lot longer than I, is that in the last six months, whether it's the fear of LHINs or not, we've actually accomplished more working together in six months than happened in the previous 60 years. So we do see it in a positive way.

Thank you very much.

The Chair: Thank you. There are about three minutes, one each. I'll start with Mr. Ramal, please.

Mr. Ramal: Thank you very much for your presentation. I was listening carefully to what you said, and I agree with most of the elements you mentioned, but I want to speak to your concerns. First, I have a question, and also some comments.

First, the question: What's the reason behind wanting every LHIN affiliated with an academic health science centre? Second is my comment, which turns into a question: Why are you concerned about the accountability agreement being different, now and in the future when the LHIN has been established, since we don't talk about it in the bill? Is there going to be a difference? You don't think it will be very important, since the LHIN people will be selected from the community, will be in touch directly with the needs and issues of the hospitals and health care providers, and will give you a better perspective, a better idea and a good relationship between the LHIN and the accountability agreement?

Dr. Smith: Let me maybe take a stab, and I know Murray will correct me where he disagrees. I think the academic health science centre component is very much related to tertiary programs. That's where tertiary programs resign—reside, rather. Some days, it feels like "resign." Beyond that is the nature of education and research, renewal of the professions. Frankly, the academic health science centres are the port of last call, when you're transferred to the tertiary facilities of the province. Beyond that, there is nowhere else to transfer you, number one.

Number two is the outreach component of both technology and treatment. It's very important, in my opinion, for all of us to be working on a playing field with common information. If academic health science centres can have a relationship between multiple LHINs, and LHINs can all have a relationship with an academic health science centre, we can in fact build the basis of research and education into all LHINs, as opposed to those that have traditionally been with teaching hospitals.

Mr. Martin: I think the bottom line is that we feel that those that do not have a relationship will be disadvantaged, because of the unique resources that are part of an academic health science centre.

Your second question?

Mr. Ramal: Your concern about accountability.

Mr. Martin: The concern is obviously any change process in terms of what drives what. You could actually end up with very different dynamics within each LHIN. You could have one LHIN that wants to see things very decentralized; you could have another that is very centralized. Who actually is going to decide on what the drivers of the overall direction of a LHIN are going to be and how that reflects into an accountability agreement?

The Chair: Thank you. Mrs. Witmer, please.

Mrs. Witmer: Thank you very much for an excellent presentation. I appreciate the co-operative manner in which you presented it, and I would certainly support the inclusion of an academic health science centre for each LHIN to have the lead.

You're proposing that there would be some criteria for the decision-making process and the orders that would be issued. I wonder what type of criteria you think should be included there, because I think this is going to be, obviously, a very contentious area once decisions are made.

Mr. Martin: An example would be the one I just referred to, whether services are to remain as they're currently distributed, or is there a desire to move to a more decentralized model or a more centralized model, or is it simply going to be economics that drives decision-making in program allocations, and those types of decisions.

Dr. Smith: Clarity of outcome and purpose, I think, is really the basis. So if we need to make decisions based on population, demography or growth versus perhaps ability to pay or economic realities, that needs to become transparent, number one. Number two, as people go back—and they will, as we try to push things together—it will be important for providers and consumers to be able to see the data that led to a decision. I think we're appealing to the view that if people have access to information and understand why a decision has been made and can replicate some of that by way of information sharing and critique, then we have a much better chance of acceptance.

The Chair: Ms. Martel.

Ms. Martel: Thank you for being here this morning. On page 4, you list your areas of potential concern. On your point number 4, I may paraphrase, but I think you said there are question marks around labour relations implications. Can I ask you what that's a reference to?

Mr. Martin: The reference is really just uncertainty. Is there intended to be an overall direction? There was discussion previously about the issues of contracting out or non-contracting out. Frankly, we would certainly hope that whatever is done is done in a way very thoughtful of the impact on organizations. There is an element of contracting out that currently exists. To go to a total ban on contracting out has a significant financial implication to it. We would hope that decisions like that would be made understanding those realities—those kinds of issues.

The Chair: Thank you very much for your presentation, gentlemen.

ONTARIO COALITION OF SENIOR CITIZENS' ORGANIZATIONS

The Chair: The next presentation is from the Ontario Coalition of Senior Citizens' Organizations, Lisa Hems, please, and Ethel Meade. Good morning.

Ms. Lisa Hems: I'm Lisa Hems and I'm with OCSCO, the Ontario Coalition of Senior Citizens' Organizations. Here to speak today is Ethel Meade, our co-chair.

The Chair: Okay. Please start your presentation any time.

Ms. Ethel Meade: Good morning. The Ontario Coalition of Senior Citizens' Organizations—we generally say “OCSCO” for short—for whom I speak today, is a coalition of 150 Ontario seniors citizens' organizations in Ontario with a combined membership of half a million seniors. Our mandate has been, from our beginning 20 years ago, to enhance the quality of life of Ontario's seniors. This includes their two top concerns, which are about appropriate and affordable housing and health care. We appreciate the opportunity to participate in these hearings, because this bill is of particular concern to seniors who, as we all know, are the major users of health care.

OCSCO stands strongly opposed to any move that increases the creeping privatization in our health care system. We support a completely public system which allows no room for the profit motive to drive any decisions concerning our health care.

Integrated health care has always sounded attractive. While the Canada Health Act, which Canadians value so highly, never contemplated anything beyond the cost of hospitals and doctors, current experience has shown that health care today has many more sectors, including pharmaceuticals; rehabilitative care delivered in the community, in the home or at dedicated hospitals and ambulatory care centres; in-home care for post-acute patients; supportive community-based care for the chronically ill, the disabled and for older persons with age-related functional deficits; and long-term-care homes.

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Every Canadian will, at some time, need care from one, two, three or more of these sectors, often simultaneously. Integrating all sectors of our system could produce what many of us have dreamed about and talked about for years: a seamless continuum of care within which patients could move as their health needs require, among various levels of care, and move without delays or hassles.

With our currently fragmented health care system, integration means a lot of changes, and change is never easy. “Transformation,” the current buzzword, means very complicated and, by definition, very difficult changes. The work of everyone involved in health care will be

affected, and the experience of ordinary citizens may be affected even more.

We are looking at how the provisions of Bill 36 would affect us as seniors and what opportunities it would provide for input from all of us, including ordinary citizens and organizations that serve them or advocate on their behalf.

Our first concern is about not-for-profit delivery of health care. Many of our members are wondering if the whole LHIN project is a backdoor way to bring in two-tier medicine. We trust this is not the government's intention, but there is not much in the legislation to reassure them. Is the purchaser-provider split merely a more palatable phrase for managed competition? We have not forgotten how public-private partnerships were given the more palatable name of “alternate financing initiatives.”

What is missing is a clear prohibition against allowing profit-seeking businesses to invest in any sector of our health care system. Experience in various parts of the world have made it abundantly clear that when the profit motive drives decision-making in a public program, the cost goes higher and the service to the public goes lower in both quantity and quality.

OCSCO believes that the managed competition model in home care is a case in point. It has resulted in for-profit agencies squeezing out more and more non-profit providers. The quality of care has suffered, and communities have suffered from losing community service agencies that have for many years played a substantial role in promoting caring and coherent communities.

Moreover, the contracting out of so-called non-clinical services to for-profit providers has been a disaster in many jurisdictions. It leads to an unstable workforce, a lack of continuity in the services provided, as well as a very dangerous worsening of sanitation in our health care institutions.

We believe that Bill 36 should include an explicit commitment to the Canada Health Act and a proactive stance on strengthening and increasing the proportion of health care services allotted to not-for-profit entities.

Our next concern is about public consultation. We have noted the provision, repeated several times in different sections, that LHIN boards and organizations of health providers must make no decisions that are not in accord with the strategic plan being prepared by the Minister of Health. That plan has not, however, been made public, so we are, in effect, being asked to comment on the means to an unknown end. Another way of saying this is that with Bill 36, we're being asked to buy a pig in a poke. We have heard no indication that public consultation about the strategic plan is being contemplated. Does the government consider the Minister of Health to be infallible?

We have not forgotten that the crucial matter of defining LHIN boundaries, as well as eliminating district health councils and their traditional boundaries, was carried out through a method chosen by the ministry. Public input was invited only on minor adjustments to the boundaries that had already been selected, yet this may

have been the most critical decision in the whole transformation process.

While we welcome the inclusion in Bill 36 of a section called "Community engagement," we are not at all sure when and by what means such engagement will be allowed. Open board meetings is an excellent first step, but it is qualified in the legislation by the provision that the cabinet will determine by regulation which subjects should be discussed behind closed doors. And instead of a specified number of days of public notice being required, the legislation requires boards to give the public "reasonable" notice of board and committee meetings. Explicit parameters for public engagement should be included in Bill 36.

We welcome also the end of cabinet appointment of board chairs and executive directors of community care access centres and their return to community control. But again, the way this will be effected is murky and obviously will take a long time. The legislation makes clear that we are not to expect any provision under the "Community engagement" section to be actualized until at least a year after the legislation has been enacted.

The provision for health professionals advisory committees seems reasonable, but it is disappointing that no provision has been made for seniors advisory committees, which the many community and health provider organizations affiliated with the Elder Health Coalition have been urging for well over a year.

The integration of care for the elderly should be an immediate and crucial undertaking for LHIN boards, because we all know that seniors are, proportionately, the major users of health care. Priority-setting workshops across the province recognized that senior health care and care for the mentally ill should be the top priorities for service integration. The voices of seniors need to be continuously available to every LHIN board. Bill 36 should explicitly mandate seniors advisory committees for every LHIN and, at the ministerial level, for the development of the contemplated strategic plan.

Our next concern is with the foundation of all policy-making, which is funding.

No policy can be put into effect unless adequate funding is made available. There has so far been no indication of the basis on which funds will be allocated to the local health integration networks. Will it depend on population viewed through an age/gender lens? Will it be considered with a more finely differentiated lens? Will it depend on the persuasiveness of the board chairs? Will it be adequate to meet the actual health care needs of each region's population?

We know from experience over the years that government policy may be unarticulated but made fully effective by government funding decisions. Home care is a flagrant example. The previous government gave responsibility to the community care access centres to provide both post-hospital care and ongoing supportive care for the disabled, the chronically ill and persons with age-related disabilities. The funding provided was never adequate for the access centres to carry out both func-

tions, and with patients being discharged from hospitals quicker and sicker, the available resources were absorbed more and more by the needs of discharged patients who were indeed sick enough to need in-home care urgently. Supportive in-home care has thus virtually disappeared, without anyone in government ever acknowledging that their policies effectively eliminated it.

The government must ensure that LHINs' funding is adequate to meet the actual health care needs of Ontario's population.

In conclusion, we hope that the government will give serious and respectful attention to the problems raised in these hearings and to the recommendations proposed to deal with those problems. Transforming our public health care system is a huge undertaking, affecting every Ontarian, and it will succeed only to the degree that the public, as well as health care providers, buy into it.

We have therefore concentrated our attention in this submission on three crucial questions:

—Will there be adequate opportunities for public input before changes are made?

—Will there be adequate guarantees that our health care will be delivered by non-profit public health entities?

—Will there be adequate funding to meet the actual health care needs of the people of Ontario?

OCSCO appreciates the opportunity to place our views before this committee, and we'll be glad to answer any questions from committee members.

The Chair: You've finished right on the 15 minutes, so thank you very much for your presentation. There's no time for questions.

1100

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2280

The Chair: The next presentation will be from the Canadian Union of Public Employees from Peterborough. You already know that there will be 15 minutes in total for your presentation and potential questions. We welcome you here in Toronto. You can start any time you're ready.

Ms. Candace Rennick: Any time I'm ready?

The Chair: Yes. We are ready.

Ms. Rennick: Did the clerk pass out copies—

The Chair: Yes, she did. Two pages, I believe.

Ms. Rennick: Yes, that's right.

My name is Candace Rennick. I'm the president of CUPE, Local 2280, which represents 200 long-term-care workers at a not-for-profit charitable organization in Peterborough, Ontario, called St. Joseph's at Fleming. I also have the great pleasure of representing over 200,000 CUPE members in Ontario as a CUPE national regional vice-president and as a vice-president to the Ontario Federation of Labour.

Our members provide services at the facility in house-keeping, laundry, dietary, maintenance, recreation and nursing services, and our members provide the best care

that they can in a seriously underfunded system which has no minimum hours of care for residents. They take the work they do very seriously, and they're more than a little concerned that the government of Ontario has done little or nothing to consult with a huge workforce about LHINs, about introducing competitive bidding, about privatizing support services or about what kind of change is really needed for the Ontario health care system.

Bill 36 specifically targets not-for-profit long-term-care facilities like St. Joseph's at Fleming in Peterborough. I appreciate the opportunity to be here with you today to share with you, on behalf of the members I represent, the concerns we have around Bill 36 and the unprecedented powers it hands over to the Ministry of Health and Long-Term Care. I thought that my own MPP, Jeff Leal, would be here today, but unfortunately he's not.

The Chair: I was with him on Friday. He's the PA for energy, and we are debating that bill, so he can't leave. But we will certainly let him know.

Ms. Rennick: Fair enough. I was actually just going to acknowledge and remind Jeff that on July 28 in his constituency, I met with him to discuss the concerns I have around the legislation—and many of those I'll provide today in my presentation—but unfortunately, to this day I have not had a response to those questions. I did, however, get a response from a Ms. Gail Paech thanking Jeff for his support of the appointment of the LHIN CEO in our area. Unfortunately, noticeably absent from that response were any answers to the questions we posed to Jeff that day. I certainly don't mean to single out Mr. Leal. Dozens of our members have met with Liberal MPPs and are still awaiting answers to the questions they have on the LHINs.

On the subject of consultation, I want to note the irony of having to travel over 150 kilometres to make a presentation to you here today, especially on something as important as health care. It seems like this may be a reflection of what business will be like under a LHIN: travelling hundreds of kilometres just to be seen and heard. I might take the opportunity to note that there was a massive snow squall on the 115. Several cars were in the ditch between two cut-offs. If circumstances were a little more dramatic out there on the roads, it's quite possible that I might not have been here to give this presentation today. It also speaks to the fact that people having to travel to access services may not be able to make those services, just based on the fact that traffic is bad, the roads are bad, and stormy weather hinders travel. And did I mention that I'm a part-time worker in a one-vehicle family with little or no resources to travel or miss work? I'm concerned that the so-called integration this legislation will introduce will require patients and family members to travel further for care. So having to travel 150 kilometres to meet with the standing committee reviewing the legislation does not bode well for the future, in my opinion.

I have split my presentation up into four categories, and I will attempt to cover all my points under the following four headings: accountability and community

control, access to services, privatization and protection for workers. I have made recommendations for each of the headings, and they've been provided to you.

Bill 36 grants little power to local communities and providers to make decisions. Instead, it transfers control over local, community-based providers to the minister, cabinet and their agents, the LHINs, thereby centralizing, not localizing. This province does not need another level of bureaucracy. We need government accountability and transparency in all the decisions that affect the way we deliver and access health care.

The proposed geographical boundaries are not boundaries that reflect our local community. The central east, which is where I will work, live and access services, spreads from Victoria Park to Algonquin Park. Seriously, what does the community of Haliburton have in common with Scarborough or even Oshawa? How likely is the community of Lindsay going to be able to compete with communities like Ajax or Whitby? How can all of these communities possibly have a voice at a single table responsible for the entire area? More importantly, how will the LHIN make sure that it is accountable to each and every community for each and every decision?

It concerns me a great deal to think that the CEOs heading the LHINs are hand-picked and will be working under pressure of potential termination if they don't meet the directions of the government, yet I would suspect that the government will be using the LHINs as a shield for political purposes.

We elected the government of Ontario, and we have a right to expect that our valuable public services and access to health care will be protected by that government. Historically, as a rule, health care and social service organizations are not appointed by the provincial government, and I would recommend that this provincial government respect that long-standing practice.

Community-controlled boards have the ability and the desire to ensure that services are available in their community, and when those services are threatened, they have the political will to change that. I'm concerned about a board that is so non-representative. Is the Central East board really going to understand the needs of the residents of Peterborough or Campbellford?

How will funding within a LHIN be prioritized? In Alberta, they have nine health boundaries, and with that, they have nine different funding models in long-term care. Can one expect that the LHIN will be funding nursing homes differently and, more importantly, can we expect the same level of care and quality of service in each LHIN?

Community control must be strengthened. I have provided a list of seven recommendations on how that can be achieved. If there is time at the end of my report, I would like to review those recommendations with you.

As services are integrated, this will most likely have the largest impact on smaller, more rural communities. In our area, Lindsay, Campbellford and Haliburton are only a few. As services are dedicated to only a few hospitals or clinics, what does this mean for our ability to access

services in our community? It suggests that you will have to travel to other communities possibly hundreds of kilometres away and, in addition, you will have to compete with all the other patients in your LHIN waiting for the same service that may only be provided at one or two facilities. What does this mean for the elderly couple trying to access services to keep their health well enough to stay in their home? What about the outpatient who isn't allowed to drive after day surgery? Are we going to keep them overnight or perhaps cover the cost of their 100-kilometre taxi fare? Or are we going to download more pressure onto the person?

In December 2005, the maternity ward at the Rouge Valley Hospital was threatened. The proposal was to temporarily close the unit and transfer it to Scarborough. Community residents feared that if it left, it would never come back, so they organized and rallied and they saved the maternity ward. That was real life, right down the road in my own LHIN: saved by the community looking out for the best interests of the public. If that was a threat for communities like Ajax and Whitby, then who is to say that couldn't happen in our own community? Imagine not being able to give birth in a community like Peterborough.

Access to local services must be protected. Integration will remove jobs and services from local communities. Picking up and moving or finding a new job is not an option and, frankly, should not be expected. People have built their lives in these communities. They work there, their children go to school there and they should have the right to expect that they will be able to access health services there. A reduction in community control and provincial accountability will make it easier for the government to force this type of reform. If the provincial government is not fearful of giving up their unprecedented powers under this bill, then they will consider and introduce the six recommendations that have been provided to you in your package under the heading "Protect Local Services and Access to Care."

Disturbingly, there are no provisions in the bill which ensure, require or even encourage LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system. Instead, these bodies will now be armed with the legal authority to privatize large parts of our publicly delivered health care system. As a worker coming from a not-for-profit long-term-care facility, I have great concerns about the negative impact Bill 36 will have on not-for-profit delivery in long-term care.

1110

The legislation not only jeopardizes the future of not-for-profit long-term care delivery, but clearly discriminates against not-for-profit providers and could result in the expansion of for-profit delivery in this sector. The legislation creates an unfair advantage to for-profit providers. Section 28 gives the minister sweeping powers over not-for-profit organizations, including the authority to integrate, merge and even close. As an employee in a not-for-profit home, these powers concern me, especially when the bill gives no such powers to the ministry over the for-profit sector.

The government of Ontario has said that the proposed legislation does not provide for more privatization. On the contrary, the simple fact that section 28 excludes for-profit providers suggests that Bill 36 very clearly opens the door to increased private delivery in long-term care. What do these powers mean for St. Joseph's at Fleming, a charitable, not-for-profit institution in our community? It means that when a facility is forced to close in the community, the not-for-profits will be forced to close first, each and every time. Such a risk would deter people from wanting to operate in a not-for-profit capacity. I would ask if anybody has a rationale or an explanation for that, and why that power would be necessary and so discriminatory. I'd certainly like to hear it.

The LHINs will also create a split between the purchasers and providers of health care. Such a split has already been established in the home care sector, where CCACs purchase home care services through a disastrous system of competitive bidding. I won't get into the stats, as I'm sure you've heard them, but the increase in for-profit delivery since competitive bidding was introduced has skyrocketed. The government of Ontario should be moving toward a model that eliminates expansion of for-profit delivery of health care, not setting up measures that support the opposite.

A recent study conducted by the Ontario Health Coalition identifies that 1,000 home care workers were laid off in a period of eight months as a result of their employer's losing contracts to competitive bidding. This model does not belong in the health care sector. The facts prove that it creates a life of uncertainty and vulnerability for workers in the sector, the majority of whom are women, most likely women of colour working with inferior benefits and often no pensions, who are among the lowest-paid. They should not have to work and live in fear of their employer not being able to compete.

In Britain, over the last 20 years they have introduced the purchaser-provider split in health care, leading to massive privatization expansion. With this split, every new contract has the potential to divert resources to the for-profit sector. So with every new contract an opening has been created for privatization. While the government of Ontario has sold LHINs as a way to integrate services, the purchaser-provider split has led to fragmentation in Britain. Funding comes by winning contracts. Private diagnostic and surgical clinics have taken over work previously done in hospitals, despite costing more, and hospitals that cannot provide a service for a set price have to subsidize it or give up providing it altogether.

All this change has led to serious problems for the British health care system. Despite more than doubling the funding since 1997, the service is running into a funding crisis with massive debts, bed closures, operating closures and thousands of layoffs. If that model is duplicated through the LHINs here in Ontario, it will create a known recipe for disaster. Does that description represent the Ontario we want: massive debts, bed closures, operating closures and thousands of layoffs? I don't believe that it does.

Privatization and decreased co-operation between providers are major threats of this reform. The institution of the purchaser-provider split and the expansion of privatization in health care and social services should not be part of this health care reform. We ask you to rethink this reform. I have attached recommendations under the title "Stop Privatization—Build Co-operation." Please ensure that these recommendations are seriously considered so that the disastrous model of competitive bidding and the expansion of for-profit delivery are prohibited under this legislation.

Do I have time left?

The Chair: You have only a minute. You can use it, or we can ask questions.

Ms. Rennick: I'm just not done. Last but definitely not least is protection for workers. Many unknowns are causing worry among workers in the health and social services sectors. Any restructuring must fully protect the rights of workers. Some changes are necessary. Please see attached the three recommendations. Workers' rights must be protected.

In closing, I must say that I don't believe the Ontario government has a mandate to plow through this type of radical reform. An approach of consultation with local communities, health care workers and the public about how health care should be reformed is much more democratic and transparent. Canadians, including Ontarians, have built a public health care system that is envied by the world. We need to continue to maintain the standard of quality, accessible, not-for-profit delivery of services that so many don't have the privilege of enjoying. We have a responsibility to maintain that standard, not just for the rest of the world but for future generations right here in our own province. While I don't claim to be an expert on this bill in any sense of the meaning, I'd like to know, as the government has constantly given us reassurances that this bill is not harmful, where in the bill does it say that it won't lead to more privatization, that it won't close hospitals, that it won't create a life of uncertainty for workers and patients and that it won't lead to an inferior level of care in our province?

I thank you very much for the opportunity to be here today. I hope that due consideration will be given to each and every recommendation.

The Chair: I know there are people who want to ask you questions, but there's no time. Forgive me for that. Maybe the whip should let her MPP know that she has questions and maybe he, or any of you, can ask those questions later on. Thank you for your presentation.

Ms. Rennick: Thank you very much.

ASSOCIATION CANADIENNE-FRANÇAISE
DE L'ONTARIO
DU GRAND SUDBURY

The Chair: The next presentation is going to be a teleconference en français. Richard Théoret, are you on the line?

Mr. Richard Théoret: Yes.

The Chair: Would you please proceed with your presentation. There will be 15 minutes in total. We also have someone who can assist us if there's a question in French. So please proceed with your presentation, and good morning.

M. Théoret: Good morning. Mon nom est Richard Théoret. Je suis président de l'ACFO du grand Sudbury.

L'ACFO du grand Sudbury a pour but de promouvoir le développement et l'épanouissement de plus de 50 000 Franco-Ontariens sur son territoire, qui s'étend des limites de la municipalité de Markstay-Warren à l'est, la Rivière des Français au sud, Espanola à l'ouest, et la ville du grand Sudbury au nord. Elle agit en concertation avec les organismes qui travaillent à la promotion des intérêts et à l'amélioration des services aux francophones dans tous les domaines tels la santé.

L'ACFO du grand Sudbury s'intéresse au dossier santé depuis déjà quelques années, et il nous apparaît essentiel de vous faire part de nos inquiétudes relativement à la réforme de santé en Ontario et, plus précisément, de la Loi 36 et de certaines de ses faiblesses.

Selon nous, des services de santé de qualité ne se résument pas uniquement à un acte technique consistant à soigner les gens. Une prestation de qualité est aussi étroitement associée à la capacité des intervenants de soigner, aider, conseiller, orienter et éduquer les utilisateurs de service. L'accessibilité à des services de santé dans sa langue constitue par le fait même bien plus qu'un respect pour la culture de l'utilisateur de service. Il s'agit d'un élément parfois essentiel à l'amélioration des conditions de santé et à l'approbation de la santé par cette population.

L'Organisation mondiale de la Santé a développé une définition de la santé qui est maintenant largement acceptée. Selon l'Organisation mondiale de la Santé, la santé est un état de complet bien-être, un état de bien-être qui est autant physique que mental ou social. La notion de services de santé prend alors un contour bien différent que si l'on définit la santé comme étant l'absence de maladie, notamment physique. Ainsi, en envisageant la santé sous un angle plus large, on se doit également de reconnaître que les services de santé couvrent un éventail d'activités qui dépassent les aspects curatifs et embrassent par le fait même des actions de prévention, de promotion et d'éducation à la santé. L'approche des déterminants de la santé développée au cours des dernières années insiste également sur plusieurs facteurs qui relèvent des comportements individuels, des styles de vie, des conditions socio-économiques.

En Ontario, le deuxième rapport sur la santé des francophones confirme que la population francophone possède des caractéristiques qui lui sont propres et qui ont un impact sur la santé. Par exemple, elle est plus âgée en moyenne que le reste de la population; son niveau de scolarisation est moins élevé que le reste de la population; elle a une moins bonne perception de leur santé; elle a une proportion de fumeurs quotidiens plus élevée; et finalement, elle a un plus faible sentiment d'appartenance.

En vertu de la Loi sur les services en français de l'Ontario, chacun a droit à l'emploi du français pour communiquer avec une organisation gouvernementale se situant dans une des 23 régions désignées. Malgré l'entrée en vigueur de cette loi en 1989, il reste difficile pour une bonne part de la population francophone d'avoir accès à des services de santé en français.

D'ailleurs, l'étude Pour un meilleur accès à des services de santé en français, publiée en 2001 et co-ordonnée par la Fédération des communautés francophones et acadienne du Canada, révélait que moins de 41 % des francophones en Ontario ont accès à des services de santé en français.

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Pourquoi est-ce si difficile d'obtenir des services de santé en français? Pourquoi est-ce que les personnes âgées en perte d'autonomie avancée, francophones et unilingues se retrouvent placées dans des établissements où il n'y a pas de services en français?

Nous le savons. Le système de la santé en Ontario doit faire face à des défis de taille : augmentation des besoins de services de santé et vieillissement de la population, réduction des revenus de la province, augmentation des coûts des médicaments, pénurie de professionnels etc. Dans ce contexte, il est vrai que des changements sont nécessaires pour permettre de mieux faire face aux défis présents et à venir.

La décision de régionaliser la prise de décision en regard de la planification et du financement des services de santé est sans doute une bonne nouvelle. En effet, les réseaux locaux d'intégration des services de santé—RLISS—devraient permettre aux différents milieux d'avoir plus de place dans la prise de décisions. Nous pouvons souhaiter des solutions répondant mieux aux besoins locaux. Cet impact est également à souhaiter pour les services en français.

Malheureusement, la Loi 36 présente des faiblesses importantes qui risquent encore une fois de nuire au développement des services de santé en français et à leur maintien. Ainsi, malgré la Loi sur les services en français, la Loi 8, et malgré la volonté de régionaliser la prise de décisions, les francophones resteront pris avec les mêmes problèmes d'accessibilité à des services de santé en français.

Rien n'indique que les réseaux locaux d'intégration des services de santé se préoccupent des besoins spécifiques aux francophones. En effet, respecter les exigences de la Loi sur les services en français n'est pas suffisant. Nous en avons les preuves aujourd'hui. Ainsi, il est recommandé que le paragraphe b) de l'article 5 à la partie II de la Loi 36 soit modifié comme suit :

« Déterminer les besoins du système de santé local en matière de service de santé »—et nous voudrions ajouter—« dont les services de santé en français »—et nous pouvons continuer—« et prendre des dispositions à leur égard conformément aux plans et priorités provinciaux et faire des recommandations au ministre au sujet du système, y compris ses besoins de financement et d'immobilisations; »

De même, le fait de respecter les exigences de la Loi 8 n'implique pas nécessairement la consultation et l'implication des francophones dans la planification des services. Ainsi, il est recommandé que le paragraphe c) de l'article 5 à la partie II de la Loi 36 soit modifié comme suit afin de garantir que la population francophone soit également consultée relativement à ses besoins :

« Engager la collectivité de personnes et d'entités qui oeuvrent au sein du système de santé local dans la planification du système et l'établissement des priorités de celui-ci, y compris l'établissement de mécanismes formels pour la consultation et la participation de la collectivité »—et nous voudrions ajouter—« dont la communauté francophone; ».

Il est écrit dans le paragraphe b) de l'article 5 à la partie II de la Loi 36 que chaque réseau local d'intégration des services de santé doit déterminer les besoins du système de santé local en matière de services de santé et prendre des dispositions à leur égard conformément aux plans et aux priorités provinciaux. Comment alors s'assurer que les réseaux locaux d'intégration des services de santé détermineront les besoins de la population francophone si le plan provincial ne le fait pas? Ainsi, il est recommandé de modifier comme suit l'article 14 de la partie II de la Loi 36 :

« Le ministre élabore pour le système de santé un plan stratégique provincial qui comprend une vision, un ensemble de priorités et une orientation stratégique »—et nous voudrions ajouter—« adressant entre autres les services en français »—et nous pouvons continuer—« et il en met des copies à la disposition du public aux bureaux du ministère. »

Finalement, rien dans la Loi 36 ne protège les francophones contre les décisions d'intégration ayant un impact négatif sur l'accès aux services de santé. Ainsi, il est recommandé qu'il soit ajouté une interdiction supplémentaire à l'article 25(3) de la partie V de la Loi 36 :

« Aucune décision d'intégration ne doit pour effet d'affecter négativement le développement, la qualité et le maintien des services de santé offerts en français. Toute décision d'intégration ayant un impact négatif sur les services en français est contraire à l'intérêt public ».

Pour terminer, je voudrais vous remercier de votre attention. Tout comme il est plus facile de prévenir que de guérir, nous vous recommandons donc d'imposer des conditions claires et précises maintenant pour la prestation des services plutôt que de tenter de réparer les pots cassés dans quelques années. « An ounce of prevention is worth a pound of cure, » comme diraient les anglais.

Nous espérons que la Loi 36 permettra de mettre un système de santé intégré permettant d'améliorer la santé des Ontariens et Ontariennes grâce à un meilleur accès aux services de santé, incluant les services de santé en français.

Merci beaucoup. Est-ce que vous avez des questions?

The Chair: Merci, monsieur. Nous avons trois minutes. Mr. Arnott, one minute each, please.

M. Ted Arnott (Waterloo–Wellington): Monsieur Théoret, merci beaucoup pour la présentation.

M. Théoret: Ça fait plaisir.

Mr. Arnott: We have heard from a number of representatives of the Franco-Ontarian community during the course of these hearings over the last few days about the issues you have raised, and I want to thank you as well for your particular expertise in this area. Do you have confidence that the government is listening to your concerns, and have you had any reassurance of amendments forthcoming?

Mr. Théoret: No, but we are proposing a number of amendments because we feel that, while Bill 8 is an adequate piece of legislation, this is a specific piece of legislation that we feel could be reinforced if certain guarantees are put in the act.

The Chair: Madame Martel, s'il vous plaît.

M^{me} Martel: Merci, Richard, pour votre présentation ce matin.

M. Théoret: Bonjour, madame Martel.

M^{me} Martel: Je voudrais vous remercier pour votre identification des faiblesses du projet de loi, mais aussi, plus important, pour les détails des recommandations pour les amendements du projet de loi. Je voudrais savoir, est-ce que l'ACFO du grand Sudbury ou même l'ACFO provincial a eu des discussions avec le ministère de la Santé ou le ministre à propos du plan provincial stratégique pour la santé? Est-ce que vous êtes impliqué dans des discussions en ce moment à propos du plan provincial?

M. Théoret: La réponse est non, parce que l'ACFO de Sudbury ne travaille pas au niveau provincial. Mais je sais qu'au niveau de l'ACFO provincial, étant donné qu'on a une restructuration présentement, je ne peux pas savoir si celui-ci travaille avec le ministère. Par contre, je sais qu'une alliance des réseaux de santé travaille étroitement avec le ministère.

M^{me} Martel: Vous attendez ce rapport en ce moment, parce que le rapport a été rendu au ministre, mais les recommandations ne sont pas publiques en ce moment.

M. Théoret: Vous parlez du rapport de M. Savoie?

M^{me} Martel: Oui, c'est ça.

M. Théoret: Oui, on n'a pas évidemment vu le rapport. Donc, on n'est pas prêt du tout à commenter sur le contenu du rapport.

M^{me} Martel: C'est un peu difficile de savoir si on va avoir des améliorations ou non en ce moment. Tout le monde l'anticipe peut-être, mais c'est difficile parce les recommandations sont encore privées.

M. Théoret: Exactement.

Le Président: Merci. Madame Wynne, s'il vous plaît.

Ms. Wynne: Mr. Théoret, I apologize for speaking in English.

I just want to follow up on the issue of the conversation between the ministry and the francophone community, and to let you know that the issue that's being discussed is that the francophone voices need to be heard and there need to be protections in the legislation. I have also not seen amendments at this point, but I know that

the report is being reviewed. I look forward to seeing those amendments that I hope will go some way to addressing your concerns.

Mr. Théoret: We're certainly hopeful also.

Ms. Wynne: Okay. Thank you very much.

The Chair: Merci, monsieur. Thank you for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1487

The Chair: We will be moving to the next presentation, Janet McIvor and Zoran Pivalica. Would you please have a seat. Good morning again. You have 15 minutes in total for your presentation. You can start any time you're ready.

Ms. Janet McIvor: Good morning. My name is Janet McIvor. I'm a registered practical nurse. I work at the Scarborough Hospital, general campus, and I am also a local activist in my CUPE Local 1487.

Mr. Zoran Pivalica: My name is Zoran Pivalica. I'm a maintenance mechanical millwright, plant operator. I'm employed by Scarborough Hospital, Grace division, and I'm a member of Local 1487.

Ms. McIvor: We are here today because we are very concerned about Bill 36 and the impact it will have on all Ontario citizens, and especially our health care system.

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First, I was a patient. I was born at the Scarborough General Hospital in 1965. Second, I'm a community member. I've spent my life in Scarborough. Third, I was a patient again when I was five years old and was seriously ill. At that point in my life I decided I wanted to be a nurse and I wanted to work at the Scarborough General Hospital. The tower was always the landmark that, when I drove by as a kid, I said I was going to work there. I did my nursing training at Scarborough General and I became an employee there in 1985. I had my child at Scarborough General and I met my life partner at Scarborough General, who also was born at the hospital and had his children there. Also, his mother worked there, his brother works there and his sister-in-law works there. I tell you all this to let you know that I'm not here just as a CUPE representative but I'm here because I'm a patient, I'm a community member, I'm an RPN and a patient advocate, and I'm an advocate of our public health care system.

In truth, there are thousands of Ontario health care workers just like me, people who care about people, who work in our health care system because of our calling to help people. We are unique. We are here and dedicated through all the difficult conditions that we face in the health care field: death, terminal illness that lingers, infectious diseases, patients and family members under tremendous distress and uncertainty, body fluids, confused patients who become violent and injure health care workers, 24-hour shift rotations, working holidays through staff shortages, high workplace injuries and always-increasing workloads. We are here because we

care. We are professionals. We need to be valued, encouraged and supported by our government, not demoralized, devalued and left with total uncertainty with regard to our futures yet again.

As an RPN and patient-employee advocate for 20 years, I've had the privilege of being on many hospital committees: nursing councils, operation plan, fiscal advisory, and healthy workplace, to name a few. I've experienced first-hand the restructuring and transformations that different governments have initiated, and in every one of these reforms, the governments have assured constituents that these were to improve our public health care system. This has not been the reality from the perspective of a patient, community member and health care worker.

The elimination of chronic care beds, long-term-care beds, in our community hospitals: We have lived through year after year of hospital budget cuts in the 1990s and the continuous closing of existing hospital beds. As an example, in 1985 the Scarborough General had 770 beds. In 1985, the Scarborough Grace had 220 beds. Now, in 2006, after our merger in 1999, we have 560 beds between the two sites. That's a loss of 430 beds in just over 20 years for the Scarborough community, which has grown substantially in that time.

No wonder there are waiting lines in emergency rooms. An easy solution is to open some of those lost beds in the hospitals you already have. We see the constant reduction in front-line staff—people who provide meals to patients, transport patients, clean their rooms and prevent infections—and a huge increase in administrative staff, whose wages are usually double that of our CUPE members. In 1996, the Health Services Restructuring Act closed many hospitals, merged hospitals and reduced beds. These forced involuntary mergers are still causing major difficulties in the fabric of these new hospitals that cannot seem to integrate different cultures and move forward as one consistent organization. One manager rep told me that it usually takes up to 30 years—a generation of employees—for the fallout from mergers to lose their negative impact on the organization culture and workplace morale. Now, with the LHINs, I can only imagine the fallout to our health care system from them and Bill 36.

Millions, probably billions, of taxpayer dollars have been spent on restructuring, consolidating, consultants and commissions in my 20 years of service. Last year alone, my hospital spent \$2,700,000 in restructuring costs. There needs to be stability, accountability and true consultation with community members and health care workers to improve the health care system. Instead, health care workers feel under attack from the government—the government we elect to represent us, the government we serve as public service employees. We are called glorified hotel workers. We face continuing threats of contracting out to private, for-profit companies. We're faced with decreased staff levels and increased workloads. We're faced with high stress and workplace injuries. Some of health care workers' illnesses are directly

related to the government's attitude and approach to health care workers. As front-line health care workers, we are dedicated to Ontario citizens providing the best patient care we can, yet with all the cuts, which we have no control over, we seem to be blamed for the wait-lines in emerg.

I have to focus on section 33 of your bill. As employees of the Scarborough hospital, we were at ground zero during the SARS crisis. As you know, our Grace site faced Ontario's first case of SARS. Our CUPE members and all Scarborough hospital staff rallied together to the aid of our hospital and community, working endless hours to do whatever we could to help. Several of our CUPE members ended up with SARS. Some of those health care workers are still disabled as a result of SARS. But we are dedicated to our calling as health care workers. We were there to meet the needs of our community and patients. That was not the case for the for-profit, private companies that service our hospital. Can-core, the security company, could not get guards to come to work. Agency nursing companies demanded triple pay. Merrik, the contract company that our hospital had just retained to provide cafeteria services, refused to start operations until the crisis was over. I can only imagine what would happen in a crisis situation, say bird flu, if all the support service workers at the hospital were contract companies. We would be up the creek.

Let's not pretend about how for-profit companies make their profits. They make their profits by paying hard-working people minimal wages with huge workloads, which of course leads to decreased quality and employee constituent poverty. I have an example of just what I'm speaking about in our hospital. In 2003, our hospital decided to contract out the cafeteria services to Merrik Hospitality Inc.

The Chair: Excuse me. Could you just move away a little from the mike? We are recording it and it's a little—

Ms. McIvor: Sorry. Where was I? I was talking about Merrik Hospitality. Our CUPE members who worked in the cafeteria made \$17 an hour. Merrik employees start at \$8.75 an hour, and their highest wage is under \$10 an hour. Imagine working full-time for \$8.75 an hour and trying to afford rent, food and clothing. In our city, I really don't think anyone could. Also, at that wage, do you really think anyone would stay in the job for long or show up at work in the hospital if there was an infectious disease rampant in it? If you are honest, you will see my point.

I've already touched on the reduction of beds at our hospital from 999 in 1985 to 560 today, and yet the LHINs are set with a clear mandate to continually restructure health care within each region. This means permanent instability for patients and workers. Your integration actually means mergers, transfers, wrap-up of services and contracting out of health services, as per sections 33 and 28. We already have projects under way at our hospital—HBS, Hospital Business Services, supported and funded by you—that are waiting in the wings

to take our CUPE members out of the hospital and have them working for this other company with much uncertainty and, for sure, layoffs, reduction in wages, possible loss of their pensions and who knows what else.

Threats of closed emergency rooms and consolidations of maternity and pediatric services leave us concerned about when we are patients. Increased pressure to reduce patient length of stay due to bed shortages pushes doctors and nurses to discharge patients who would be better off staying in the hospital for a day or two more. Patients who are post-discharge or visiting our emergency rooms end up back in hospital with infections or more serious complications, which would have been avoided if they had been allowed to stay in hospital a day or two more. One patient was told by his surgeon, after having vascular surgery, "You really should be staying in hospital for a week to avoid infection, but with the new directives and bed cuts, this is now a day surgery procedure and you go home straight after it." That patient ended up with an infection, costing our health care system more than if he had been able to stay there for a couple of days.

The increased pressure and decreased ability to provide the excellent patient care we desire to give are causing severe burnout and stress illness in health care workers. Many nurses, when asked if they would go into nursing today if they were just starting out, say no. With the negative, uncertain future of our health care system, it will be difficult to recruit nurses, added to the already difficult shortages of nurses. Many of our hospitals have slogans such as, "Your health care family," or "Caring together, caring for your community." We are the community and deserve healthy workplaces to live in, not stress levels over the top, pressure to reduce that jeopardizes patient care and infection control, workloads that foster mistakes and injuries, and increased sick time due to pressure and stress which trigger many illnesses and aggravate pre-existing health conditions. Mission and values statements of our hospitals talk about prevention, trust, honesty, compassion, integrity, accountability, valuing staff and commitment to continuous quality improvement. How can that be real when all the government seems to care about is reducing budgets and putting pressure on hospital boards and administrators to cut, even when they know it is not in the best interests of patient care or their staff? It seems you are taking the "care" out of "health care," and if this restructuring continues much longer, many of your dedicated doctors, nurses and clinical and support service workers will lose their "care."

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In SARS, we were heroes. Now, we are expendable. We are called an essential service, and that is why we are bound by HILDA, unable to strike after negotiations don't work and having to use the arbitration system to settle contract disputes. Yet it seems, by this government's plans, that we are not essential, and if we end up working for contract, for-profit companies, I guess we cannot be bound by HILDA. What does that mean to our health care system?

What our health care system needs is for all Ontarians to work together. You need input from all perspectives—community members, support staff, nurses, doctors, managers, administrators and, most of all, patients—when talking about health care reform. With all perspectives on the table and debated, we could collectively come up with real solutions to the issues. As well, all Ontario citizens have a right to know the implications of this legislation and the facts around LHINs.

Please keep our health care system public. Consider our seniors who have multiple health conditions and their inability to get from hospital to hospital to care for various health issues which all hospitals will not provide in the near future. Think of those who cannot afford to pay for transportation to get the care they need. Please think about us, your health care workers, whose wages could be cut in half if the for-profit companies are allowed into our public health care system. Please think about all Ontario citizens equally when deciding to deregulate services that many cannot afford. Please continue to advocate for higher standards of living for all Ontarians instead of increased profits for private companies. Amend Bill 36: Help us put the "care" back into "health care."

The Chair: You still have a couple more minutes.

Mr. Pivalica: In our submission, there is a part I want to cover, but because of the time, we will leave the rest for questions.

The Chair: Okay. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation. I want to focus on your point about what happened during the SARS crisis, how employees of the hospital stayed on the job, providing health care services, and employees of the private companies decided not to. In the submission you didn't have a chance to read, sir, I noted that you say you saw workers of the contracting companies walking off the job and asking the companies for reassignment from the Grace. You also referenced the problem that, even though the hospital was offering triple pay to nursing agencies, they couldn't get nurses. Do you want to expand on that?

Mr. Pivalica: Yes. Our security is contracted to Cancore, and security guards walked off the job and requested to be reassigned to other organizations; they didn't want to perform the job during the SARS crisis. Also, because the ICU and the emergency department were hit very hard by SARS and we had a lot of nursing staff—a total of 64 staff members—affected by SARS, we needed nursing agencies to bring nurses into the hospital, and the agency was requesting triple pay. The hospital offered that, but still there were problems getting nurses in during the crisis.

The Chair: Ms. Wynne.

Ms. Wynne: In the five days of hearings, we've heard three or four times from CUPE each day, and I do appreciate your taking the time to come as an individual to present. But I guess one of my questions—you asked a rhetorical question about what the health system will look like after LHINs. Our approach is that the health system will look more coordinated, that there will be a

plan in place. You talked about what happened with restructuring under the previous government. There wasn't a plan. There wasn't a provincial plan, and there certainly weren't local plans. What we're trying to do with this legislation is push some of that planning function into the local community so there can be coordination, because that has been sorely lacking.

The answer from us to your question is a more coordinated system. Do you want to comment on that?

Ms. McIvor: Yes. First of all, I don't see the LHINs' geographical regions as local at all. As Scarborough hospital employees, we are grouped with Peterborough and Haliburton, and we don't see how that is local. In fact, we know that even though we're in the GTA, there are five different LHINs in the GTA.

When I was talking, I was really focusing on the aspect of how all these different restructurings, year after year, impact the staff who provide care. The fact is, it's causing major stress, major illness. We need health care workers to focus on caring for patients. It's not just nurses; it's the people who are making sure that rooms are clean and that infection isn't spread, it's the people who are transporting patients and being there to support them when they're going through the worst experiences of their lives.

The Chair: Ms. Witmer.

Mrs. Witmer: Thank you very much. I would respectfully disagree with Ms. Wynne's comments. When we underwent the restructuring of the health care system, there was a plan, and that was to provide a continuum of services. In fact, you would not be in the position you are today with family health teams if we had not initiated the primary care model and put in place the first teams, and if we had not gone through an evaluation of all the hospitals and looked at where we could provide services better and closer to home in a more efficient manner.

I understand the concern of these presenters. You're saying the bill gives the government and the minister unlimited power and takes away democratic rights from the public and communities, and we're certainly hearing it. This bill is not about local autonomy. One of the LHINs has 1.5 million people in it. Obviously, you don't know the chair and you don't know the members. Could you just expand on what power you see that is quite concerning to you?

Ms. McIvor: From my understanding, the Minister of Health can basically direct LHINs to do whatever he wants to our public health care. My understanding is that the minister can order that they wrap up services in the hospitals and let private, for-profit companies come in and provide those services. To me, that spells disaster. It also very much concerns public servants, who are here trying to do our best to provide good care to patients.

The Chair: Thanks very much for your presentation.

CANADIAN HEARING SOCIETY

The Chair: The last presentation before we break for lunch is from the Canadian Hearing Society, Toronto: Gary Malkowski, Kelly Duffin, Fred Enzel and Penny

Parnes. Good morning and welcome. You can start your presentation any time you are ready.

Ms. Kelly Duffin: Good morning, Mr. Chair and committee. I'd like to thank you very much for allowing the Canadian Hearing Society to present before this distinguished group. We will try to contain our comments to 15 minutes. However, we do have two accommodations: We have sign language interpreting and we have captioning, and that does create some lag. We'd appreciate your understanding of that.

My name is Kelly Duffin. I'm the president and CEO of the Canadian Hearing Society. I'm here with my colleagues, Penny Parnes, vice-president of hearing health care; Gary Malkowski, our special adviser on public affairs; and Fred Enzel, our CFO.

The Canadian Hearing Society is a 66-year-old non-profit organization that provides services to deaf, deafened and hard of hearing people in 28 offices across Ontario. Those services include health care services, such as audiology, hearing aid dispensing, speech-language pathology, hearing health care and mental health counselling.

We come before you today, then, in two capacities: (1) as a community health care provider in the voluntary sector, and (2) as an agency serving people with disabilities.

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Before we begin, I also wanted to introduce two other community health care and disability service providers with us today: Linda Kenny, from the Canadian Paraplegic Association Ontario, and Christopher McLean, from the Ontario arm of the Canadian National Institute for the Blind. Their organizations and ours have prepared individual and independent submissions to this commission, but we endorse each other's submissions and we're pleased to provide a shared statement of principles which will be attached to our written submission for this committee's consideration.

First let me say that in principle we support the concepts attached to the creation of the LHINs: coordinated services that are customer- or patient-focused; services that match community needs; an efficient and effective health care network; and promotion of wellness, independence and aging in place. Those are in keeping with the philosophy and approach of CHS as well as CPA Ontario and CNIB.

That said, we want to make strongly four recommendations regarding the legislation as proposed:

(1) Community health care and non-profit providers, their specialized knowledge and skills, must be valued, funded and be represented at all levels of decision making.

(2) Recognition for people with disabilities and their distinct needs and rights to choose and access services must be articulated in the legislation.

(3) The drive for local planning and accountability must be balanced by the need to account for province-wide priorities and consistency of service and must not

increase the administrative burden on provincial health providers.

(4) Due process—including consultation, observance of current statutes, transition plans that minimize service disruptions, and an equitable appeals mechanism—must be better defined in the legislation.

Ms. Penny Parnes: I'd like to speak first about community health care and non-profit providers, their specialized knowledge and skills. These must be valued, funded and represented at all levels of decision-making.

What the LHINs have recognized conceptually is that community health care providers are key players in the system. Generally speaking, we can provide non-acute services quickly, effectively and efficiently. We also have a key role to play in health maintenance and prevention that assists the whole system in managing costs, reducing demands on service and promoting wellness. However, community health care providers can be the forgotten or less understood players in this continuum of health care. We're not as high-profile and sexy as the large acute-care service providers and we often have critical mass only at the provincial level, not at the local level.

In order to make appropriate decisions in the sector as a whole, it will be critical for LHINs to have appropriately balanced legislated representation on LHIN boards and committees as well as at the provincial advisory table. This will be especially important in consideration of people with disabilities.

Although it is outside the scope of the legislation per se, it must be said that in addition to having appropriate representation, community health care partners must be adequately funded. Many recent studies substantiate the claim of the Ontario Community Support Association that for every \$1 of funding, the voluntary sector delivers \$1.50 worth of service. In part, this is due to the unpaid contributions of volunteers; in part it is due to the fact that most voluntary sector organizations are not fully funded by governments. While there have been some welcome increases in the last two years, the decade before that we saw the erosion of 15% in agency operating expenses throughout the sector. This is according to a study done by Howarth in 2003 entitled *Shaken Foundations: the Weakening of Community Building Infrastructure in Toronto*.

In the cases when a simple approach to seeking service providers is based only on a lowest-cost-provider basis, damage to long-standing service providers and tremendous disruption in patient service have occurred. In a sector where salaries already lag behind other sectors, and indeed even behind hospitals, these factors have combined to make staff recruitment and retention increasingly challenging.

For these and other reasons, it is critical that the LHINs planning process not enable further erosion to this major, underfunded and cost-effective sector. Clearly, you have identified that a strong potential value of the LHINs will be in enabling hospitals to focus on those activities which only they can do, such as surgeries and

emergency procedures. These tend to be high-cost. Community health care providers could, and should, assume increasing responsibility for other services with the potential to reduce both cost and wait times. This must be premised, though, on appropriate funding for the community health care sector, not further erosion of that funding. Improvements in the health care system as a system cannot come on the backs of agencies that are already overstretched and on the backs of staff who are chronically underpaid.

Our recommendations regarding the legislation is that representation of the community health care partners must be enshrined in the legislation. Thank you.

Mr. Gary Malkowski (Interpretation): I'm going to discuss people with disabilities and their rights to access.

The duty to accommodate and access health care is a right affirmed in the Charter of Rights and Freedoms and confirmed by the Supreme Court of Canada's 1997 *Eldridge* decision and within the Ontario Human Rights Code. Indeed, being able to communicate your symptoms or medical history and being able to understand what is being said by doctors and nurses is the absolute cornerstone of health care. Without communication there can be no care.

It must also be said that the LHIN legislation is the first major piece of legislation that will impact the lives of people with disabilities since the passage of the Accessibility for Ontarians with Disabilities Act, the AODA, in June 2005. It is imperative that the LHIN legislation get it right and reflect the letter and the spirit of this new law.

Within the LHIN legislation there should be guaranteed equal access to consistent special services no matter where people live, and this access should not be subject to discretionary funding by LHINs. In addition, in the spirit of the people-centred approach to the LHINs, the ability to choose a service must be the patient's choice.

The LHINs must make sure that all aspects of the system are accessible irrespective of the type of disability, and that the specialized services required by people who are deaf, deafened or hard of hearing are retained and expanded to meet the growing population of seniors and others requiring these accommodations.

We recommend that within the preamble of Bill 36 there should be an amendment that includes affirmation that persons with disabilities, consistent with the Ontario Human Rights Code and other legislation in the spirit of the AODA, will be guaranteed equal access to special services regardless of where they live in Ontario. The legislation should affirm that the LHINs do not have the discretionary power to opt out of funding specialized services for persons with disabilities, which has been in place as a result of the community care access centre legislation.

Mr. Fred Enzel: Continuing, the drive for local planning and accountability must be balanced by the need to account for province-wide priorities and consistency of service, and not increase for us the admin-

istrative burden on provincial health providers. As it currently stands, the legislation is silent on the issue of provincial programs, agencies and their interface with the Ministry of Health and the LHINs.

In many cases, these agencies provide the best of both worlds: responsiveness to local needs; and provincial planning, standards, controls and a cost-effective centralized infrastructure. These agencies cross LHIN boundaries and have many funders for several interconnected programs.

The Canadian Hearing Society, as well as CNIB and CPA Ontario, would like to see this type of approach accounted for in this legislation. We believe that types and quality of services should be consistent from community to community. We are also concerned that inefficiencies and added cost may be created if 14 different agreements have to be negotiated and contracted by one provincial agency. For these reasons, the possibility of centralized provincial multi-year contracts need to be explicit in the legislation.

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In addition, we also strongly suggest that applications, agreements, funding formulae, forms and processes be as consistent as possible across LHINs so that those service providers who will have to deal with more than one location will not have to detract from service delivery to manage differing types of paperwork.

We've made two recommendations in this area: to allow for some central, provincial contracts to assure equitable service and controls; and to the extent possible, assure consistency in LHINs paperwork so that the administrative burden on service providers operating in more than one location doesn't divert resources from service delivery.

Ms. Duffin: Our last point relates to due process, including consultation, observance of current statutes, and transition plans that minimize service disruptions. An equitable appeals mechanism must be better defined in the legislation.

This legislation as written would override much current legislation, including the Statutory Powers Procedure Act. The extent of that authority is disconcerting. While we believe the stated intentions to be true and fair, without appropriate due process in the legislation, there could, down the line, be dire unintended consequences.

For instance, the proposed legislation would give powers of integration to MOH, even when they are not the sole or even primary funder. Furthermore, many not-for-profits operate a series of interrelated programs to meet the needs of their consumers. The cessation, transition or integration of other services could have serious implications on the viability of other related programs. By extending the power of the minister and the LHINs to assets not funded by the government, these foundations could be completely decimated.

Also, Bill 36 leaves many details to regulations and grants the minister discretionary powers to dispense with public consultation before introducing a regulation, so

much of what comes into force could be enacted unilaterally.

The finality of integration decisions is also troubling. A health service provider can make a submission to have the order reconsidered only once, and within 30 days of the order. Once the order has been reconsidered, it is final and there is no right to appeal. A health service provider can only apply for judicial review, and the test for review is whether the decision is patently unreasonable, which is a very high standard. There is no compensation for loss or damage and no right of action.

Transition plans and timelines are also not mentioned. Staffing considerations, for those of us who work with unions and have lay-offs clauses, leases, legal and other wind-down or expansion considerations, need to be incorporated. Whether a provider is being closed, contracted, expanded or partnered, a too quick or ill-considered transition can cause major disruptions in client service. It can also create undue hardship on the affected service provider, who may have to consider labour and union issues, leases and other legally binding arrangements that can be complicated, costly and sometimes actually impossible to amend.

Many agencies such as CHS enjoy the support of the public through donations and fundraising. We must also remain true to the obligations which accompany such public trust.

Finally, the LHINs and the minister must consider the public interest when issuing integration decisions and orders, but Bill 36 does not set out a definition for this term as do the Public Hospitals Act and the Commitment to the Future of Medicare Act. If this is a guiding principle, it should be better defined.

This issue of public interest is particularly true for people with disabilities. If, as is the stated intention of LHINs, the desire is to view health care from the perspective of the clients, the question must be asked of the clients which services they need integrated. CHS, for instance, provides a very integrated spectrum of services for people who are deaf, deafened and hard of hearing, which enables them to have a series of appointments at one location. The trend in some areas of government, though, is to dis-integrate this type of service under the banner of integrating all disability services. For the client, however, this then means attending at multiple locations, several that present barriers to them, rather than at one. At a minimum, the legislation should assure that there would be no reduction in services or in access to services for people with disabilities.

As it is currently written, LHINs' statutory objects focus more on system management than on patient care and experience. While a stated goal is transparency, there is no safeguard against unilateral decisions and actions. If the true focus is a consumer or patient focus, there must be more attention given to their perspective and more consultation in the process.

Our recommendations in this area are:

—Provide for due process before issuing an integration decision or order.

—Include criteria for making integration decisions and orders. These criteria should take into account patient care, including access, choice and quality.

—Public interest should be defined; and

—There should be an allowance for transition periods of six to 12 months to implement integration orders.

In summary, we want to be clear that we are not wedded to the status quo, afraid of change or driven by the desire to provoke fear; nor do we question the sincerity of the stated intentions or assurances given during this transformation of health care in the province. But legislation cannot account for intention or assurances that are not documented in it. Legislation must be written to govern not only those currently in power and executing a current vision but for all those who may come, including those with different views. For those reasons we are bringing, as invited, our sincere recommendations about how to best capture the goals we share in this important new initiative. Thank you for your time and attention.

The Chair: Thank you to all of you for making the presentation. There's no time for questioning.

We will break until 1 o'clock.

The committee recessed from 1208 to 1302.

BURLINGTON HEALTH COALITION

The Chair: Our first presentation is from the Burlington Health Coalition, Mr. David Goodings. You can start any time you're ready. There's 15 minutes in total.

Mr. David Goodings: Thank you. I'm very pleased to be here representing the Burlington Health Coalition, which is a group of about 200 citizens in Burlington who are concerned about health care issues. We have been studying Bill 36, and in a broad way we are in support of the bill. We think the integration of the delivery of health care services is something that has many benefits, and that it should be given at a local level, where the LHINs would be in touch with the needs of the people within their geographic area; that is highly desirable. So we broadly support the LHINs legislation.

We also are pleased that the meetings of the LHIN boards and their committees will be open to the public. We are a little bit concerned about what it says about notices: that notice of meetings will be given "in a manner that is reasonable in the circumstances." We would like to see that spelled out in a little more detail, as would be done, say, for school boards or municipalities. However, we do generally support the reservations.

What I'm going to say now are just one or two concerns we have about the legislation. The first is that the ministry will produce a strategic plan. This strategic plan, of course, is unavailable at the moment, so we don't know what's going to be in it. We assume that certain goals will be stated and also that there will be budget targets. We would really like to see more about the strategic plan tabled before the bill is enacted.

With regard to the process by which LHIN board members are chosen, we would like to see that process be as transparent as possible. In the interest of the public

knowing what's going on, we would like to see that spelled out a little bit more.

It's clear from reading the act that a great deal of authority is going to be given to LIHN administrators and boards and also to the ministry. As we see it, that really means a shift of authority and decision-making from the hospital boards and CEOs, and also from the boards and CEOs of other health care providers, to the LHIN administrators and their boards. I understand that is probably needed in order to bring about the integration of services, which didn't seem to happen very well under the district health councils. We understand that more authority is going to be needed; however, there are concerns that so much power is being shifted to the LHINs and to the ministry that this government or a future government, perhaps of a different political stripe, could use this legislation to impose rather deep cuts on hospitals and other health service providers. We view that with some anxiety.

The area that is of greatest concern to people in the Burlington Health Coalition is the steady growth of for-profit corporations delivering health care over the last few years. I realize that the LHINs legislation is an administrative structure and doesn't deal directly with either for-profit or not-for-profit, but we have looked at the legislation to see whether it encourages for-profit or not-for-profit delivery of health care, and have come to the conclusion that it is really quite neutral with regard to those two types of delivery, except for what I think are minor considerations, such as that Bill 36 can bring about the amalgamation of not-for-profit corporations and agencies but not for-profit ones. However, our reading of the bill is that it does nothing to impede the growth of for-profit delivery in Ontario. We know that the government is planning numerous new hospital projects along the P3 model—or the new term, the AFP model—and it seems clear that a private partner in one of these P3 projects will demand that many of the services in a new hospital be privatized, that they be sent out to different corporations. So it seems that it does open, or at least make possible, for-profit delivery of services on a larger scale than we have at the present time. Although the bill is neutral, it does seem to allow that to happen.

A final concern is that the bill seems to make possible a price-based competitive bidding model of the kind we have seen in home care. That was introduced in home care through the CCACs about six years ago. We believe it had a very bad effect: lowering the quality of service in home care. We are very concerned that this price-based competitive bidding model might be used in areas like long-term-care facilities, the delivery of mental health—mental health associations—also Meals on Wheels and, possibly, public health. There are many areas where that model could be used, and we view that with considerable anxiety.

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Just to sum up, we broadly support the LHINs initiative of bringing the administration of health care closer to the communities in which they are doing it. We have some concerns about how the board members will

be chosen. Our major concern is that it does nothing to impede the for-profit delivery of health care in the province. Finally, we are worried about the competitive bidding model being used in more areas of the health care sector.

The Chair: Thank you. There are about three minutes, one minute each. Mr. Ramal, you may wish to ask some of the questions, please.

Mr. Ramal: Thank you for your presentation. I know you mentioned so many different concerns that we listened to across Ontario, and also some kind of built on speculation and assumption. For instance, you mentioned that P3 was going to lead to privatization and more private services. I think our minister and our government were clear on this issue: It's 100% publicly run and operated and controlled by the public, not by private institutions.

The second concern is about shifting the power. We listened this morning to many health professionals and people who have been dealing with the government for a long time. They won't see in the LHINs a shift of more power from the past to the present. So they believe the power will be the same, that there will be no difference. As a matter of fact, it will be enhanced, because the ministry has a huge administration in Toronto. It would be difficult to deal with a huge budget, \$33 billion, altogether from Toronto. That's why the LHINs have been created: to assist the minister locally and to give advice in order to enhance and consolidate health services in the province of Ontario, all because we believe in publicly funded health care accessible for all.

Mr. Goodings: Do they not see it as taking power and decision-making away from hospital boards and CEOs?

Mr. Ramal: No. We listened this morning to the Ontario Hospital Association. They mentioned that clearly. They've been professionals in this matter for a long time. They've dealt with the government. They don't see any difference.

Mr. Goodings: On the question of the P3s, I'm really talking about non-clinical services. If there's a private partner, the private partner will expect and perhaps demand in the contract that all the non-clinical services be under the control of the private partner. That's where we see them being more expensive and very likely of lower quality.

The Chair: Thanks very much. Mrs. Witmer.

Mrs. Witmer: Thank you very much for appearing before the committee and representing those in Burlington who are obviously extremely concerned and follow health issues closely. You've indicated that you have some concern around the appointment process, and we have heard this morning from different groups that they're not sure that the boards, as presently constituted or to be constituted in the future, are necessarily going to represent the people in that particular LHIN. I guess I would ask you, how do you think we can ensure that those boards actually represent the people in the LHIN?

Having said that, these are not going to be your neighbours, because in the central LHIN, you've got 1.5 million people. So it's not as though we're shifting power

to local communities, because we're not. In fact, all power remains in the hands of the minister. What could we do?

Mr. Goodings: I think the process should be more transparent. What I'm thinking of is that the members of a committee that would appoint the administrators would be known. In my previous life, I was an academic at a university, and I know how committees were set up there to find and appoint, say, a dean of a faculty. You would know who was on the committees, and people would then be able to talk to them and make their concerns known. I was thinking of that kind of process.

Mrs. Witmer: That's right. As I say, we keep hearing that they should be representative of the community and transparent.

The Chair: Thank you. Madam Martel, please.

Ms. Martel: Thank you for coming in from Burlington today to make the presentation. You're going to correct me if I'm wrong—I'm going to paraphrase—I thought I heard you say that there's nothing in the bill to impede the move to for-profit delivery of health care. I would agree with you and go further and say that in fact there's a lot in the bill that just influences that even further. If you look at the fact that the government has not put in a specific clause that says that LHINs will not acquire services or pay their providers through the competitive bidding model—we know in home care there's been a shift from about 18% to now over 50% of those in the sector that are for-profit that are providing care.

Secondly, in section 28 the minister is allowed to integrate not-for-profit providers, but the bill says nothing about the for-profit providers, so there certainly is a great concern that this will be done at the expense of the not-for-profits.

Thirdly, section 33, of course, allows the minister to essentially outsource any prescribed non-clinical service. There's no timeline given for that, there's no identification of what the non-clinical service is or who's going to get it, but it's certainly clear that other people have pointed it out as the area where privatization is going to occur.

Over and above that, significant job losses could occur under any of those three scenarios. My concern is that money that goes into health care should be going into patient care, not into the profits of some of these providers. I wonder if you would want to comment on that aspect of this bill and certainly the areas where privatization can occur.

Mr. Goodings: I agree very much with what you have said and I don't think I have any more comments to make.

The Chair: Thanks very much for your view. You did answer the question.

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION, LOCAL 345

The Chair: We will go to the next presentation, from the Ontario Public Service Employees Union, Local 345

from Peterborough. It's CarolAnn Bolton. Welcome, ladies. Good afternoon, and you can start whenever you're ready. You've got 15 minutes' total time for your presentation. Thank you.

Ms. CarolAnn Bolton: Good afternoon. My name is CarolAnn Bolton. I have worked at Peterborough Regional Health Centre for 25 years, currently as a ward clerk in the birthing suite. I am the president of OPSEU Local 345, which represents 250 clerical staff, half of whom are part-time and almost all of whom are women. Our members have been providing clerical and support services, some for more than 30 years. Members of Local 345 live in and around the Peterborough area, which includes many townships, as do many of their families. This places us in the unique position of being both employees and patients for the health care services provided in our hospital.

The LHIN is called the Central East Health Integration Network. It is the second-largest LHIN in Ontario, with a population of 1.5 million people. Travel time in our region, from Haliburton in the north to Scarborough in the south, is 203 kilometres or 2.5 hours, depending on the weather.

Peterborough Regional Health Centre currently serves four counties, with a population of approximately 350,000 people. We have a very large geriatric population, many of whom have no access to a family physician. Many residents are living in poverty. How can our most vulnerable handle the extra traveling time to access the health care that they require? Would this not reflect a two-tier system? Those that can afford to travel will get timely health care and those that cannot will get delayed or substandard care.

This regional hospital is the largest employer in this region, employing 2,000 staff plus 600 volunteers. In 2004-05, we had 85,018 emergency visits. We have the busiest emergency department in Ontario.

As health care workers, we know that the system is not broken but is severely underfunded and has been for over a decade. Last week, Dr. Gary Hill, an emergency room physician, wrote a letter to MPP Jeff Leal detailing the conditions and appalling state of the emergency room at Peterborough Regional Health Centre. Dr. Hill has been working there for 14 years and he states that the situation has never been worse.

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The editor of the Peterborough Examiner identified our health services as "A Decade of Shame...."

"Patients who lie for days on narrow gurneys in the busy, brightly lit hallways of the Peterborough Regional Health Centre—that's the shameful stain on local health care that just won't go away."

The problem is that Peterborough Regional Health Centre doesn't have enough beds, and it doesn't get enough funding for the ones it has. A detailed Ministry of Health review found that Peterborough needed 480 beds in 2005, but it gives funding for about 330 beds. With that formula, having patients in the hallway is a given. The hospital actually has 50 more beds that are partially

funded, but every time one is used, the hospital goes a little further into debt. The Ministry of Health recognized how badly underserved this community is when it approved construction of a new Peterborough Regional Health Centre, scheduled to open in 2008 with 489 beds. Our current bed status is 335 beds.

Can anyone here explain, then, why the new, two-year budget imposed by the ministry is supposed to slash another \$2.3 million out of annual hospital spending? There is no logic, but one would have to question if this is a deliberate creation of crisis for our health care system to justify the drastic changes that will be imposed under LHINs Bill 36.

From a health care worker's perspective, I must state that Bill 36 scares the hell out of me. We have survived the restructuring commission, layoffs, Bill 136 and SARS. The proposed LHINs structure will create chaos across the health care system by moving services around within the region and opening the door to privatization and competitive bidding.

In our hospital, new initiatives are being introduced that will downsize our workforce. They are voice transcription, automated staff scheduling and payroll system and back office transformation. During the past year, the hospital has issued layoff notices and services have been lost, all in the name of being accountable as the hospital had a deficit. The services lost are the day hospital and the prenatal clinic. We no longer offer childbirth classes. The public health unit now provides this service, but at twice the cost to the patient.

The rehabilitation day hospital was a multi-disciplinary, comprehensive service offered to patients in the four counties served by Peterborough Regional Health Centre. Its primary mandate was to assist persons with complex neurological and physical rehabilitation needs to remain independent in their own homes rather than become hospitalized or take up a bed in a long-term-care facility. Patients presented with a variety of diagnoses, including stroke, 54%; other neurological diagnoses, including brain cancer and the effects of chemotherapy and radiation, seizures etc., 19%; multiple sclerosis, 14%; acquired brain injury, 10%.

I can speak from experience for the excellent care provided by the day hospital. In December 2002, my husband suffered a stroke at the age of 46 and, following his hospital stay, utilized this outpatient service with much success. Had my husband suffered his stroke today, the degree of his recovery would be questionable, as he would not have the rehabilitation and care provided by the day hospital. Although he had been on a waiting list for CCAC, it was over six months before he was contacted by them.

As of September 2005, this service was eliminated from the hospital before it could be established in the community. We were reassured by hospital administration that in a short period of time the CCAC would provide this program. Last week, five months later, the director of the CCAC, Stephen Kay, advised that funding from the government has not yet been established, but he

was hopeful it would be in place in another three months. This is unacceptable.

The community raised these concerns at a public forum in the spring of last year. Hospital and CCAC administrators and our local MPP were all present. All acknowledged the need to keep this service intact but have failed to do so. How long must those most vulnerable wait to receive the care and support they so desperately need? Another shame.

Last year, the Women's Health Care Centre, currently a department of the Peterborough Regional Health Centre, was identified as a service to be eliminated in the balanced budget proposal. This threat is still there. Last year alone, the Women's Health Care Centre had 21,940 contacts. Women without family doctors were able to see a nurse practitioner for a routine physical, cervical health and birth control. Abortion services, counselling for sexual abuse, sexual assault and eating disorders are also provided.

The lack of family physicians is a critical issue for women in Peterborough. The development of family health teams has been a slow and inadequate process to date. Due to an overwhelming outcry from the women and men in this community, the Women's Health Care Centre was left out of the balanced budget scheme.

Seamless and transparent transfer of service from the hospital to the community has not been a reality in Peterborough. How could the ministry and the hospital even think that closing the Women's Health Care Centre and the day hospital before the establishment of replacement services in the community would be acceptable?

What I do know about the LHINs, as detailed in the present legislation, is that they will be controlling our future. They will determine the funding and delivery within our region. This means permanent instability for patients and workers as services and programs are continually restructured, transferred and contracted out. Where is the strategic plan? Why haven't the public or health care workers been allowed to give any input? Why aren't the LHINs accountable to the public? What will happen to the current board of directors at our hospital? What will their local role be? The Minister of Health has an enormous amount of control over the LHINs, and the LHINs are a highly centralized control centre for the minister.

What will be the economic impact on our community when the largest employer in the region eliminates staff or contracts out the jobs, resulting in lower wages and no benefits? Money from good paying jobs that once flowed into the community will be no more.

Can you tell me who will look after our hardworking, dedicated and professional workers when they are told they no longer have a job or, due to competitive bidding, they have to reapply for their job at a lower wage rate? What will happen to their pension plans? What does the human resource plan look like?

Currently, health care workers are doing more with less. Our hospital is dirtier, staff morale is extremely low,

staff are ill due to injuries and burnout, workload has increased and expectations of the staff are higher.

Nursing shortages became so critical that extra money from the government for incentives for nurses became available, but nothing for the support staff. Yet the support staff, especially clerical staff who use computers, are faced with constantly changing programs and need educational upgrading. But due to the fast-paced changes, they are never given an opportunity to enhance their skills.

With the construction of our new hospital, members from our community have made generous donations. The question is being asked whether these dollars will actually go towards services and equipment in our own hospital or whether they will be transferred to another community. With the possible transfer of services going to other hospitals, I know of several community members who have called the foundation to pull their donations.

As the legislation stands now, there are many important questions that must be answered. Providing answers for these questions is a responsibility that you must fulfill.

In summary, the LHINs Bill 36 is flawed and must be rejected in its present form. The impact of this legislation on health care workers will be devastating. Health care is the provision of care by people. There must be a human resources plan, and it must include layoff as a last resort; measures to avoid layoff; voluntary exit opportunities; early retirement options; pension bridging and protection of pension funds; and retraining options.

A transitional fund should be established. Similar to the private sector, the Health Sector Training and Adjustment Panel should be resurrected.

Stop this legislation now. Involve the public. Do a proper provincial strategic plan. Put protections in place for health care workers. If you don't take care of your workers, you have no health care system. Thank you.

The Chair: Thank you. There's only one minute left. Mr. Rinaldi, if you can have a short question, please.

Mr. Lou Rinaldi (Northumberland): I'll make this very brief, Mr. Chair.

Thank you very much for your presentation. I know you ask a lot of questions in your presentation. We only have a minute, and I'd love to address them all.

You talked about the size of the Central East LHIN. Ninety per cent of the riding I represent is in that LHIN. I represent the riding of Northumberland, Cobourg east. The question needs to be asked: Yes, it's a large LHIN, but how does that compare to the one LHIN we have now in Ontario? So when you talk about being closer to the people—we've divided the province into 14 sections. I think that's smaller than what we have now, with the centre being down here. That's just to give you some perspective when you say it's a huge LHIN.

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I did visit your hospital, because a lot of the folks in my riding, at least in the west end of the riding, go to Peterborough. Yes, it needs repair. It's not in the best shape. I visited it about a year ago. That's why I believe a

shovel has been put in the ground. A new hospital is being built that has been long-awaited. You folks were working out of trailers, and that's not a decision we made. We're trying to fix that. So when you say that conditions are bad, we understand they're bad. I think the need is recognized for the new hospital, which I believe is being built.

The other question I'd like to try to address is, what happens to hospital boards? We made it very clear: Hospital boards are going to be there. Whatever they did yesterday, they're going to be doing after the LHINs. I addressed my local hospital board in Cobourg last week, and I'm going there to speak to the staff tomorrow.

I think we're throwing a lot of fears in the air. That's my opinion, but I respect your opinion as well. I think we need to work with concrete ideas; that's just maybe a comment.

The Chair: Unless there are any questions from anybody, we'll move to the next presentation.

Ms. Marion Burton: Can I just comment?

The Chair: Surely. You're over time, but that's fine.

Ms. Burton: As health care workers, we're asking you, where is the strategic plan to deal with the issues of the workers? The LHIN identifies the possibility, the opportunity to severely change conditions of work for the workers. You have not described that at all. These LHINs do not address that issue, and that's what we're saying to you. You need to focus on how you're going to support health care workers. If you don't, I hope you don't wind up in the hospital.

The Chair: I think you have made that point. I thank you both for your presentation.

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION, LOCAL 581
ONTARIO NURSES' ASSOCIATION,
LOCAL 111
CANADIAN UNION OF
PUBLIC EMPLOYEES, LOCAL 1487

The Chair: The next presentation is a joint union presentation from the Scarborough Hospital: Janet McIvor, Patricia Ignagni, Pat Collyer and Susan Brickell. Is that close?

Ms. Susan Brickell: You almost got all our names.

The Chair: I mentioned four people.

Ms. Brickell: I think you did well.

The Chair: One is missing? Okay. You can start your presentation. There's a maximum of 15 minutes.

Ms. Brickell: Thank you for giving us this opportunity to speak to you today. We're here from the Scarborough Hospital. Pat Collyer from OPSEU technical is not here today. My sister unions would like to introduce themselves.

Ms. Patricia Ignagni: Patricia Ignagni, OPSEU Local 581, Scarborough Hospital.

Ms. Janet McIvor: Janet McIvor, CUPE Local 1487. I'm deferring to my sister, as I took too long this morning.

Ms. Brickell: I'm Susan Brickell. I'm an RN and president of ONA Local 111 at Scarborough Hospital.

We're here today with 86 years of experience at the Scarborough Hospital among the four of us—Pat has the most; she has 30 years. Unfortunately, she's not here. She has to be at the hospital today.

Personally, I was born at the Scarborough Hospital, I've been a patient there many times, my son was born there and I've had family members die there. I live and work in the community. I've worked for 20 years at Scarborough Hospital. I'm an RN. I love my job, but I'm very frustrated at my inability to provide the care to my patients that they deserve. I can't provide even minimal care anymore.

Over the last decade, the Scarborough Hospital has lived through many, many crises. In 1996, we dealt with health service restructuring. When a lot of hospitals were closed, we had to amalgamate. We took on dialysis, our burn unit went to Sunnybrook—it was a major, major upheaval. In 1999, we had Bill 136, the amalgamation of Scarborough General with the Scarborough Grace Hospital—again, huge chaos, huge confusion. In 2003, we had SARS.

Even though it's seven years later, we are still not one facility after the amalgamation. We still have two sites; it's two hospitals. There's animosity. There's a lot of disparity between the Grace and the General. Staff are torn between where they started and where the employer thinks they are today. This doesn't serve our community well.

The cost of the amalgamation was to be offset by the savings; however, we feel we are spending more dollars now. We have more management, administrators and vice-presidents than we had before, and we have far fewer front-line workers. As well, we've lost many beds.

Our fear is that the LHINs will simply be a larger version of this experience. You're proposing 14 regions, each with a nine-member board, plus all the office and human resource staff you'll need. Where is this money coming from? When the patients arrive in the emerg, shall we inform them that we have no bed or staff because that money is paying for more administrative staff? Our members will experience more fear: fear of change, fear of job loss, fear of an inability to do their jobs. This will lead to increased stress, increased illness and increased sick time and a generally unhappy, dissatisfied staff.

Let's stop and think about that. When you or someone in your family is ill and in emerg, hopefully not dying, do you want to be cared for by an unhappy, stressed, ill worker or someone who is secure in their work and able to focus all their knowledge and attention on you or your family member?

On to 2003: The Grace site was SARS Central, Canada. Welcome to TSH-Grace. This should have been a huge wake-up call for everyone. We were not, nor are we today, prepared for a pandemic, and it will come; it's a given. I have grave concerns. I do not believe we will cope with it. I'm sure you've heard from every hospital worker that the hospitals are filthy: absolutely, disgust-

ingly filthy. I'm on the health and safety committee. The inspections I do—it's absolutely disgusting. Imagine not cleaning your house for two months. That's the filth that's in the hospitals.

We found that hospitals employed at multiple facilities during SARS. Why do I bring this up? Infection, cross-contamination. People have to work at multiple facilities, so they carried the SARS germ throughout the city. I believe we are lucky we did not see more deaths from SARS. It was pure luck. It wasn't knowledge; it wasn't skill. It was luck.

In my bargaining unit at Scarborough Hospital, I still have a number of RNs off as a result of SARS. I feel they never will return to nursing. I have a couple who have returned, but they'll never be able to do front-line nursing again. We had RNs die. We had health care workers and their families die as a result of SARS. During SARS, we saw outsourced workers refuse to work and walk off the job, and yet the dedicated Scarborough Hospital staff came in daily, without regard for their own lives. I personally was quarantined three times. My entire family was quarantined the third time, as I was investigated for SARS. It was frightening. Three years later, I'm still there.

I urge you to listen to those who have taken the time to speak to you. I urge you to keep our health care system public, strong and accessible to all.

I'll defer to my sisters, if they have anything to add.

Ms. McIvor: I get a chance. I just wanted to say that we are here jointly. This obviously is a very serious matter to us. In my 20 years of involvement in the hospital and in union activity, this is the first campaign where ONA, OPSEU, SEIU and CUPE have joined together to stand strong for health care. We, as local representatives, are going to our members jointly and having sessions like this, and I believe that is happening across the province. I can't say enough about our concern for the future of our health care system. You have to understand that we are your community too. You have to think of us when you're making these changes, because if you don't, you won't have a health care system when you're done.

The Chair: Any other comments? If not, there is a minute each. I'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I can certainly hear the passion and concern.

The minister has said over and over again that there was extensive consultation with stakeholders in the province prior to the introduction of Bill 36. Your comments seem to indicate that maybe you weren't involved in that consultation.

Ms. Brickell: We're front-line workers. We're never involved in any consultation.

Mrs. Witmer: Would your union provincially—

Ms. Brickell: I don't believe so; otherwise, our provincial union leaders wouldn't be together as well arguing against this.

Mrs. Witmer: So what is your main recommendation to the government, seeing that we have a bill here that obviously does not reflect your input? What should the government—

Ms. Brickell: It should take a step backwards. We need to take a step back and actually have some consultative process with front-line workers, those who actually do the job and those in the community. I've spoken to multiple people in my community, from patients to neighbours to family. Nobody has an idea what I'm talking about.

Mrs. Witmer: I know. Nobody understands LHINs. They don't know about them.

Ms. Brickell: When I say "LHINs," they go, "What?" They have absolutely no idea. My ex-husband works as a paramedic. Neither he nor any of his co-workers know.

Mrs. Witmer: So what should the government do? Should they go back and rewrite the bill?

Ms. Brickell: Before rewriting, you need to actually have some consultation with the worker bees, as I refer to us.

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The Chair: Madam Martel.

Ms. Martel: Thank you for your presentation. I want to focus on the cleaning, because this wasn't clear to me. In an earlier presentation, we heard about the contracting out of food services. Is the problem with cleaning that it has been contracted out already or that there has been a cut in staff as a result of the restructuring?

Ms. Brickell: A huge cut in staff. We need to save money. We're in a huge deficit. There's not enough staff to do the work. It's continual reorganization and restructuring. In the last 10 years, hospital workers have been restructured multiple times. We're dealing with it almost on a yearly basis at the Scarborough Hospital.

Ms. McIvor: I can speak to that: Last year, part of the \$2.7 million that was spent was to take apart a program we had called PSA. They were multi-skilled workers who did cleaning, portered patients and also delivered meal trays. It was a good system. At first we fought it, as a union, but when it came in, it worked well for the patients. The wait times for tests were shorter, and it did work well. The problem was that each PSA was to a floor, instead of a centralized system. Instead of making it centralized and having managers and coordinators over that, they eliminated it, which caused major packages, early exits. They created a new role—housekeeping aide—going back to the centralized service. And afterwards they realized, "Oops, we made a mistake. We have piles of gaps that no one can do," and they created a TA position, which is basically what the PSA was. With the cleaning issues right now, sick calls aren't being replaced. You have people with huge workloads getting ill, getting stressed, and then when someone calls in sick, the other staff have to cover two units. They're not getting replaced. That's just adding to the workload and to workplace injuries. You can check it out: We have major workplace injuries in the hospitals. It's like a coal-mine, compared to other places.

The Chair: Ms. Wynne.

Ms. Wynne: I want to thank all of you very much for coming and talking to us. It's extremely helpful to us as we consider the legislation.

A couple of things: The minister has committed himself to no net new bureaucrats, so the closure of the district health councils, the closure of the regional offices and the closure of some of the CCAC admin offices should offset. You were worried about the costs and the administrative costs. There should be an offset there.

The other point I wanted to make was on the consultation strategy. In this legislation, there is provision for ongoing consultation. There is also provision for a provincial strategy to be developed; there's a consultation plan being developed on that. So consultation is integral to what is going to roll out here.

I understand that people don't know what LHINs are yet, and that is part of what's causing the fear. But the minister is committed to coordinating the system. That's why he's doing this. When he came into office, he discovered that there really wasn't a health system. There were silos, and there weren't the connections that needed to be there. I personally think that SARS made the argument for doing this. We must have better communications; we must have plans in place across the province if we're going to be prepared for future catastrophes.

I don't know if you want to comment on any of that, but that really is the root of this bill.

Ms. Brickell: I did want to say one thing. I think what you're creating is more silos. I think you're disjointing the system even further. Now it's going to be battles within each LHIN for the dollars and who gets those dollars, and health care consumers are the ones who are going to end up holding the bag.

Ms. Wynne: I hope you're wrong. I believe you're wrong.

Ms. Brickell: I don't think I am. Unfortunately, I'm a little tainted when it comes to the argument that one price should offset the other cost. I don't think that will happen. I've seen bureaucracy. I'm not young. I've been nursing 20 years, and I've seen many layers of bureaucracy in hospitals.

Ms. Wynne: But when you wipe three out and replace it with one—

The Chair: Thank you very much for your presentation.

ASSOCIATION OF ONTARIO HEALTH CENTRES

The Chair: Next is the Association of Ontario Health Centres, Adrianna Tetley and Scott Wolfe. You can start your presentation. Good afternoon.

Ms. Adrianna Tetley: Good afternoon. I'm Adrianna Tetley, executive director of AOHC. With me is Scott Wolfe, our policy adviser.

The brief is being handed out, and I am going to mostly focus on the recommendations that are on pages 7 to 14. Before I start that, I do want to give a little bit of background of who we are. The association is the policy and advocacy association for non-profit, community-governed, interdisciplinary primary health care in Ontario. We currently represent 54 community health centres, 10

satellites and seven aboriginal health centres across the province. In particular, we provide accessible, community-governed, interdisciplinary, not-for-profit primary health care services; health promotion focusing on social determinants of health; prevention and treatment of illness, including chronic disease; and building capacity for people and communities.

When we first heard about the LHIN legislation in terms of integration and partnerships, we realized that community health centres have basically 30 years of experience, and when we understood what a LHIN was—I often refer to the CHCs as actually mini-LHINs. Part of my comments are going to be from that perspective, especially in terms of the size of the LHINs that are being proposed.

Recently, over the last number of months, the minister has announced a number of expansions to the community health centres, so we are going to grow significantly over the next couple of years as we move into LHINs, increasing the number of people who receive care at community health centres to 550,000. We have also recently, because of our integration and partnerships, been recognized as a vehicle for diabetes education across the province, and we've had recent success in terms of getting Early Years funding established as base funding instead of program funding. So we recognize that the government recognizes community health centres as one of the vehicles through which we can deliver care.

The perspective we bring today that is unique is that we have a strong focus on barriers-to-access populations, none of which many of the other providers before you do, and the other really important one to which I draw your attention is that we're the only primary health care model that is going to be under LHINs. This is a bit of a dichotomy. The rest of primary health care is outside of LHINs. We're not sure, in terms of some of our comments, about how that planning is going to happen when we're the only primary health care model inside of LHINs and the rest of the family health teams and all the physicians are outside of LHINs.

If you turn to page 7, I'm going to focus specifically on the recommendations, which are tied to a number of principles. The first principle is that Ontario requires a culture of health service coordination and integration, not merely a system navigation mechanism. We believe very strongly that people have to be supported at where they enter the system, wherever that may be, and that every door must be the right door to services. We believe that an effectively coordinated system, not the role of an individual sector, organization or individual, is the answer. Also, a culture of system integration and coordination is needed, not any single system navigator.

We're actually recommending that there be an additional clause added to the legislation that prohibits any single care sector or organization being supported or funded, via the act or through regulation, to perform an exclusive system navigation role for clients.

The second principle is really focusing on the whole issue of community engagement. While we support in

your bill part III, section 16, around community engagement and the requirement to do community engagement, we have a major concern because the word “community” is not defined. It is left wide open. Does “community” mean that they only need to consult the health system providers? I would reiterate that part of the community is the employees who work in the system, and our recommendation 2 is that you actually add a definition of “community” to the legislation, a definition that includes all clients who receive service, the residents of the geographic area, the full complement of health service providers that are funded, and the health care institutions and providers, so that you really have a full consultation of the community. As it is left now, it could indicate that “community” is left to just the service providers as a whole.

The next point, recommendation 3, is really related to community governance and the definition of community governance. We have a very strong concern that community governance could mean that the government will move towards having one governance structure over the entire LHIN. We’ve seen the example in Quebec, where they have moved towards a community governance structure where the whole city and all the health providers are under one community governance section. In other parts of the country there have been examples where community governance is one structure over a large region.

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We do not believe that this is a definition of community governance. We have 54 very unique community health centres, and the reason is that they are community governance. They meet the needs of their local neighbourhoods, not the entire region’s. Yes, we understand that each region is different, but we also say that a CHC governs a smaller area and they are unique. Even in the city of Toronto, even in Ottawa, they are unique because of the needs they are serving in their community. We would really like you to strengthen the definition of community governance and not allow actually in the legislation for that wholesale community governance. There’s a really strong feeling that maybe community governance is protected now, but down the road future governments—even if this government’s committed to community governance, there’s no protection in here that in the future community governance will disappear, especially if it’s broadly defined as a volunteer board over a very large area. For us, that’s not community governance.

As well, on recommendation 4 around integration, there is no advance notice if there’s an integration order. At this moment, a community health centre, for example, could get a letter today saying, “You are no longer going to provide this service,” or, “You are going to inherit this service,” and there is no requirement in the bill for any advance notification for potential integration orders.

Even when the appeal process is there, the appeal process says that you only have 30 days. Our recommendation is that there be at least 30 days’ notice of the potential of an integration order, so that people can start having solutions.

Principle 3 is really talking about safeguarding the programs in the community when we have a large, decentralized, locally managed system. I echo the concerns of the previous speaker, but the concerns are equally felt in the community side. When you move services from one organization to the other, what is the plan? What is the plan to move workers from one system to the other? What is the plan to move funding from one system to the other?

The huge concern is that—and we’ve seen this. We’ve seen this in community health centres, for example, even as recently as last year where programs for breast cancer or chiropody ceased to exist in hospitals; they closed their doors. The next day, they’re sent down the street to the local community health centre, if there is one. The community health centre got no advance notice, didn’t know that it was coming, and the dollars did not follow. You’re trying to solve the problem of orphaned patients in terms of doctors, but you’re creating potentially all kinds of orphaned patients if the money, the resources don’t follow the services to where they’re going.

We have a very strong recommendation 5 for a one-way valve where we’re basically saying that if you needed to get it into community care, the dollars, the resources, the people have to flow with that to the community. We believe that the answer is in the community, but adequate resources have to follow with them. We also clearly want to be protected from any deficit that might follow in a large institution.

A very strong point is that there’s one large hospital in one of the LHINs and we have six community health centres in that LHIN. The deficit of that hospital equals the full budget of all six CHCs. There’s a very strong concern that if the hospital, even if it goes with a balanced budget, one year later has a deficit budget—they’re not allowed to borrow money—are they going to do that on the backs of community governance?

Across the country, there are examples of regulation and legislation in two different cases where there is protection for community groups, that they are not going to have to absorb large deficits from large institutions that incur the deficits historically from year after year.

We also have recommendation number 6 that elaborates on that, where it basically says that the legislation should be amended to not allow a health service provider to retain resources specifically dedicated for service that has been ordered to cease or it has decided to cease as a result of an integration order and that they meet with whoever the recipient group is to ensure that the appropriate resources are continued so that there’s a continuation in services that are received by the client.

Our recommendation number 4 is about the continuum of care, especially those facing barriers to access. This recommendation is largely around the whole question of people are going to look forward to the issue around—that there are services. “With a small community, they both have mental health. This must be a duplication of service. Let’s just get rid of one.” The idea is, especially when you’re dealing with barriers to access—and in a lot

of these community-based organizations, even though they're serving mental health, because you're dealing with culturally appropriate services or a specific focus on mental health, it may not at all be a duplication. You will probably be filling different needs, and different client-based groups are being needed. The stronger recommendation is that through integration and partnerships, groups work together. So the solution is not just elimination of services.

Recommendation 7 is also focused on the issue, and we have a very specific example. In your recommendation, you talk about the service providers in and for the geographic area of the network. We do have community health centres whose physical building is on one side of the boundary but whose entire catchment area is on the opposite side of the boundary. A lot of our satellites are in two different LHINs attached to that community health centre. Even now, as they are having the early consultations, they want to talk to somebody in the other LHIN about their satellites. They're saying, "Well, you belong in LHIN 1. You don't belong to LHIN 2. Go talk to LHIN 1." But all of their services are in the second LHIN. So how is this going to happen? We're actually recommending an additional clause that says, around health service providers: "including health service providers mandated to provide services to clients or population groups that span across LHIN boundaries." Our catchment areas are not restricted by the highway, where people are going, and it's a very strong concern.

As well, right now there is a very strong problem in that there is really no major appeal process. The appeal process for any integration order is only 30 days. That is very insufficient. It needs to go to at least 90 days. You have to appeal back to the same body who made the first decision, and there is no appeal further than the LHIN. So once they've reconsidered it, that's the end. So a 30-day window is very much too short for dealing with that.

Principle 5 is about provincial health system standards and assurances that all health sectors will be involved in provincial and LHIN-level planning. In our brief that we submitted back in May, we were very clear that if you're going to move to LHINs, all the primary health care should be in LHINs. That is not the decision that was made. The decision that was made is that community health centres are in LHINs, but the new family health teams, all the doctors, are outside of LHINs.

We're very concerned about where the provincial health care standard is going to be developed for primary health care; what is the role of LHINs with family health teams? In particular, you have a clause in your legislation that is contradictory as far as we can see it. This is referring to part I, section 2 of the act, where in one part of the act you actually define who is a health service provider. Then, in the next subsection, you've got exclusions, and who's excluded are the college of doctors, the College of Chiropractors of Ontario, the college of physicians, the college of dentists—a number of colleges. Yet physicians, chiropractors etc. are employees of community health centres and hospitals. I'm assuming the OHA would raise

this issue with you as well. So what is the status of a doctor who works at a CHC, a chiropractor who works at a CHC, and yet they're being excluded in the legislation under subsection (3)?

Our recommendation is that a clause needs to be added that basically says: "A notable exception to clause 1, above, is any member of one of the professional colleges listed in clause 1 who provides professional services through a health service provider, as defined in part I, section 2. In such cases, the professional is deemed to be a member or a component of the health service provider." They can't be in one or the other. They need to be as part of the health service provider. There shouldn't be an exclusion.

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Recommendation 10 is about the health professionals' advisory committee—very open-ended as to who should be on it. It has been left totally open for the LHIN to decide who is on your professional advisory committee. Our concern, especially when we're the only primary health care organization in the LHINs, is (1) that this committee needs to ensure that all regulated health professionals are represented on that committee so it's not just a committee of doctors; and (2) that you ensure all models of care are provided. So a doctor who works at a hospital doesn't necessarily bring forward the views of primary health care.

We could clearly be excluded from those advisory committees, and we're the only model that the LHIN is responsible for. We are recommending that more specific language be introduced in there, defining the kinds of folks that need to be on that body.

Our final recommendation is around provincial strategic planning, and the requirement—it describes that the minister's duty is to develop the provincial strategic plan. It's clear in there that the LHINs have to consult with the community on developing their LHIN plans based on a provincial plan. We have frequently been asking who's establishing the provincial plan; what are the consultations for the provincial plan; how are we going to ensure that community health centres across the province are going to be funded fairly equitably, whether you're living in Ottawa versus Timmins; and where are these standards being decided? There is nothing in this legislation that says that the minister will do this. It doesn't say at all how those provincial standards are going to be decided. For us, that is really critical. We understand that the LHINs are going to implement the provincial plan, but the question is, what's the provincial plan and who's determining it? What are the standards at a provincial level?

Since this has come out, we have frequently asked for a table to be set for primary health care where provincial standards for primary health care be set, which would then guide the work of the LHINs. So far, there has been no response to that. Part of our concerns is that all of these 14 different LHINs are going to be one provincial plan, and yes, there might be standardization—there may not be; we're not sure yet—but the question is, who's

doing it in the first place? Where is the consultation for that? We would like to see a very clear plan established around consultations for the provincial plan, as well as that the minister has to deal with whatever report the Ontario Health Quality Council comes out with—it's supposed to be an independent body—that somehow there's legislation in here that the findings, the recommendations, from the Ontario Health Quality Council also need to be incorporated in any decisions and considered in terms of any future guiding of the minister's policies and plans.

Overall I would say that, with trepidation, we are looking at trying to figure out how the LHINs will work. We're working in support of the legislation. However, the concerns around properly engaging communities are key: ensuring that communities are properly resourced when this transition happens—we all know international research that shows you have to invest in primary care, in prevention, if we're going to save the system in the long run. We also want to ensure, though, strong equity for health care professionals across the system no matter where they work. And we want to ensure that basically, the comment at the end, as I just got the signal—we know that an ounce of prevention is worth a pound of cure—that CHCs are well-resourced and positioned to help the new health system as it moves forward. We're looking forward to trying to figure out the solutions for this plan.

The Chair: Thank you for your presentation. There's no time for questioning.

ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES

The Chair: The next presentation is the Association of Local Public Health Agencies, and it's Linda Stewart and Larry O'Connor. Good afternoon. You can start your presentation any time you're ready.

Mr. Larry O'Connor: Thank you, Mr. Chair. Hello. I'm Larry O'Connor. I'm past president of ALPHA, and I've been joined by the executive director of the association, Linda Stewart. The Association of Local Public Health Agencies represents the public health units across Ontario. We work closely with medical officers of health, boards of health and the affiliated organizations that represent the senior managers in public health units. We are pleased to have this opportunity to comment on the proposed legislation, local health integration networks, Bill 36.

First of all we want to recognize the progress the government has made with their ambitious transformation plan and their sustainable health care system. The achievements to date are commendable, and ALPHA is monitoring them with very close interest.

An observation, if I might, about the draft legislation: It doesn't clearly reflect the values of the health care system enshrined in the Canada Health Act, the five fundamental principles: universality, accessibility, comprehensiveness, affordability and public administration. I

would like to suggest that these fundamental principles could be reflected in the preamble of the final legislation. I think it would go a long way to putting out the point to the public just where the government feels this health care system belongs. A strong signal is needed.

While public health units do not fall under the jurisdiction of LHINs, they certainly have an interest in the mandates and the planning functions of LHINs. One would perhaps ask why we're here, then. Clearly there are many issues that people have raised, and you've heard other presentations. I guess the point that we want to make is the value and the role that health units provide locally around integration and partnerships. It's always been a foundation, that public health units operate at a local level. Health units back home certainly work closely with a wide range of organizations, including family physicians, long-term-care facilities, social services, school boards, just to name a few. Certainly it's the population health that we work with those providers in.

Due to the relationships with public health and many of the health services providers that now fall under the LHINs, ALPHA wants to ensure that public health units continue to be consulted and that as the LHIN implementation process moves forward there's a role for us to have some interaction at a local level.

In addition, it's important that local, community-level public health units participate in the planning processes of LHINs to ensure that existing partnerships in each health unit remain intact. There are partnerships that have been involved in public health for a long period of time in the community. We want to make sure that they stay in place. You heard from the previous presentation about the interactions with primary care providers and some of the planning processes and the education and health promotion that we do as health units. Obviously, we want to make sure that remains intact.

We're pleased to see that the draft legislation makes provision for community engagement in the LHIN planning process, and ALPHA and the public health units across Ontario look forward to being involved in this process. Perhaps it may need to be strengthened, as we've heard from some of the previous presenters today.

I guess we're here to congratulate you for moving forward on this. We're not part of the process, but we still want to be involved at a community level with some of the communications.

The Chair: Any other comments? No. Thank you.

We have two, three minutes each, and I'll start with Ms. Martel.

Ms. Martel: Thank you for being here today. I appreciate the presentation. Why do you think that public health units were left out of the legislation?

Mr. O'Connor: Quite frankly, I think we're pleased as an association that they were left out of the legislation. I don't think it was appropriate that we would be included in the legislation. If we take a look at the move the government has made in recent times around Operation Health Protection and around the capacity review commission, the number of commissions and reports that

have been undertaken, we don't feel that it would have been appropriate for us to be included in that. We're certainly waiting to hear the outcome of the capacity review's final report. I guess there are some concerns perhaps that local health unit board members may have; they are actually concerns that they would have wearing another hat, perhaps as a municipal councillor, like I am.

Ms. Martel: Yet public health units receive provincial money, and municipal money as well. You're absolutely right: you need to be involved in this process because there are any number of alliances that have already been formed which support primary health care very particularly, but support other aspects of health care as well. Since you're not formally members of LHINs, what is your view of how you can participate on an ongoing basis in a way that's reflected in the legislation?

Mr. O'Connor: One part of the legislation, where it talks about community engagement—we think that's the role we could play. I think the language could certainly be strengthened, but that's perhaps a role that we do play, with that interaction we have with community organizations.

Ms. Linda Stewart: There are a number of committees that are proposed in the legislation, in that section, and public health would, I'm sure, be more than happy to be part of those committees.

Ms. Martel: We've got the health professionals advisory committee and a health service provider committee, but I'm not sure how you'd fit under either of those, actually.

Ms. Stewart: We certainly have groups of health service providers that work in health units that aren't strictly health care providers that are typically under the LHINs. You have public health nurses, public health inspectors. We have groups of different folks who interact with the communities and interact with the various organizations that are inside the LHINs, so there could be some benefit to them being together, working together.

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Mr. O'Connor: For purposes of discussion, perhaps an example is public health dentistry, where our public health dentists hold clinics within the community. Obviously, for planning purposes, we think we should work together. Sexual health clinics that are held in the communities: Obviously, there's a service component to that and an education component to that. We'd want to work together with the health care community to make sure we're offering the best service and at the same time involving them in the education process.

The Chair: Thank you. Mr. Levac.

Mr. Dave Levac (Brant): Thank you very much for the thoughtful presentation. Over the last little while I've heard some serious concerns being laid before us by various groups and individuals regarding the changes that are being proposed within this. Can you reflect for us on some of the changes that have taken place with the public health provisions over the years or the decades, from your experience, and once those questions were answered and once the process was put into place, the types of

things that bettered the public health system in terms of trying to alleviate some of the concerns that are being expressed now? You sound like you're going to be partners with this, even though you're not attached, but could share some expertise on how those changes get implemented and show for the improvement of the system.

Mr. O'Connor: Certainly, we've been the subject of much consideration in recent times. One way that we as an organization interact with the government could be, for example, through our conferences, where we bring forward resolutions to talk about immunizations, where the government has actually acted upon our recommendations and has strengthened them. Certainly, it's a way that we've been able to work together with the government.

The review of mandatory programs is another one that's about to be undertaken. There's been much discussion in the past about actually reviewing these mandatory programs: Are they effecting the positive changes in the health of our population that we want to see and are we measuring them appropriately? Some of that has to be reviewed, and so we're continuing to be a part of that process. Some of it still remains yet to be seen; for example, the CRC, the report that is still outstanding. Linda, did you want to add?

Ms. Stewart: If I can add something there, the initial creation of the mandatory programs, which was back in the 1980s, was a reaction to something that may result or an issue that may certainly be perceived as possible with LHINs, that there may be inconsistency, that there may be no standards between LHINs. The mandatory programs were developed and in fact solved that issue. As Larry suggested, it's quite a few years later, 20 years later, and they're recognized as out of date and in need of review. But the implementation of that kind of standard that applies across the province can really help, recognizing that they need to be reviewed from time to time.

Ms. Wynne: Thanks very much for coming today. Earlier in our proceedings, the district health councils were referred to as toothless at one point. I'm just wondering how you see the LHINs—because you obviously see their coordination role as being important—what the key component of that is. What is it that you're going to be looking to the LHINs to do once they're up and running?

Mr. O'Connor: If I could speak to that community engagement portion of it, I think that's one that we won't know until that actually takes place. District health councils did have municipal representation on them in the past. The legislation doesn't allow for that to take place but the community advisory committees' intention that I'm hearing from local chairs is that they want to engage people in that sort of discussion. So perhaps the proof is still out there.

One thing that the district health councils did quite well was provide good planning advice at a local level for the Minister of Health. Quite often reaction to that good planning advice takes years and years before we ever see anything come out of it. Whether the LHIN gets

tied to that long-time frame around funding—certainly the last presentation actually spoke to some of the realities around funding.

Ms. Wynne: But you need that planning advice and you need it to be acted upon?

Mr. O'Connor: That's right. We obviously have the staff that can do some of that; for example, our epidemiologists provide that sort of expertise that can be used to complement some of the other work.

The Chair: Mr. Arnott.

Mr. Arnott: Larry, it's always good to see you back at Queen's Park. I want to thank you very much for your presentation. You have said that it's an important opportunity for your organization to be able to participate in the community engagement part of this. I was wondering if you would care to give this committee some advice as to what you think the guiding principles ought to be in terms of how the government would proceed with community engagement and exactly how your association would fit into that.

Mr. O'Connor: I think it could be strengthened. We've heard that from the other presenters today, that that role could be strengthened. I'll give you a local example, if I might. In Durham region we have a network of health care providers that come together, from the hospitals to the community providers. Our MOH for the region, Dr. Kyle, actually chairs that group. There is collaboration that takes place around local planning initiatives and they're all kept in touch with the realities of the budgets as they go through the process. It's not mandated anywhere that that type of collaboration needs to take place, but it does at a local level. I guess the fear is that when you put something out that's very prescriptive and doesn't allow that community development piece to take place, then you run the risk of overlooking some opportunities.

Mr. Arnott: In the communities that I'm privileged to represent, there are those kinds of efforts to collaborate that make a big difference in terms of the delivery of health care, and prevent small problems from becoming big ones and ensure that people continue to work together to maintain their foremost interest, of course, which is the improvement of care to the patient. I want to commend your area for pursuing that kind of approach.

Mr. O'Connor: In public health, our primary concern is population health, as opposed to that of the primary health care providers. There needs to be, obviously, that interaction at the local level at every stage through the process.

Ms. Stewart: If I can add some thoughts around principles, two really key ones that come to mind are inclusivity and being a bit careful about who decides who needs to be inclusive—what does that really mean?—as well as ensuring that an open atmosphere of what I would call dialogue exists so it's clear that everyone has a voice, everyone's voice is respected, and everybody is heard and so on.

The Chair: Thank you very much for your presentation.

ELDER HEALTH ELDER CARE COALITION

The Chair: The next presentation is from the Elder Health Elder Care Coalition. Just for the record, we have a letter that I received from Susan VanderBent. We will all have a copy. I'll read the first part:

"The board of directors of the Ontario Home Care Association is a member of the Elder Health Elder Care Coalition but is not a signatory to the Elder Health Elder Care Coalition submission to the standing committee on social policy. This is due to differences related to the content of some of the recommendations in the submission...." and so on. Do you have a copy? Okay. You can start your presentation whenever you're ready. Thank you again.

Ms. Gerda Kaegi: My name is Gerda Kaegi and I'm co-chair of the coalition. My colleague is Donna Rubin, a member of the steering committee of the Elder Health Elder Care Coalition.

What might be most useful to you—on the inside cover of our brief you will see a list of the coalition members who support this submission. I think that is in part a response to the letter that you cited at the beginning.

We are an umbrella organization that brings together seniors, social activists, health care professionals and providers interested in contributing to older persons' health and well-being. Our mandate is to advocate for healthy public policy for seniors. We have acted as an advisory group to Minister Smitherman and other ministry officials. We welcome this opportunity to convey our coalition's views and recommendations on Bill 36. As I said, the members who support this brief are listed.

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We believe that integrating all sectors of our system could produce a seamless, cost-effective continuum of care in which patients would be able to access various levels of care as their health needs require. In looking at Bill 36, we are looking at how its provisions would affect older persons in particular and what opportunities it would provide for input from all of us, including ordinary citizens and organizations that serve and advocate on their behalf.

The integration of care for the elderly should be an immediate and crucial undertaking for LHINs boards, because we all know that seniors are proportionately the greatest users of health care. The LHIN priority-setting workshops across the province recognize that senior health care and care for the mentally ill should be top priorities for service integration. We are going to argue, and we do argue, that the voices of seniors need to be heard and be available to every LHIN board and to the minister.

Therefore, we have our recommendation 1, which you see in the brief: There must be a seniors' advisory committee for each LHIN and for the minister.

We also, following presentations you've had from others, believe the legislation should be extended to the principles and spirit of the Canada Health Act. I don't

think I need to go through that argument, but we also say that it should eventually include pharmaceuticals, rehabilitative care delivered in the community, in-home or at dedicated hospitals, in-home care for post-acute patients, supportive community-based care for the chronically ill and the disabled and for older persons with age-related functional deficits and long-term-care homes.

Recommendation 2 asks for that extension with an explicit commitment to the Canada Health Act.

We are concerned, as a coalition, for the non-profit delivery of service, and we're afraid that it will be eroded. Bill 36 has no explicit provision for the LHINs, the minister or cabinet to preserve or expand public not-for-profit delivery of health care services. Seniors and the advocates are deeply concerned about the absence of that. Our brief cites some of the evidence to show that publicly funded and not-for-profit delivered health care services result in higher quality care at lower cost. Studies in many jurisdictions show that P3 initiatives have a higher cost and result in a deterioration of the quality of services.

So we've come up with recommendation 3:

—Amend the objects of the LHINs to include strengthening not-for-profit delivery.

—Amend Bill 36 to require that any transfer of services must be to not-for-profit providers and that only if these cannot accept the transfer of health services should transfer go to for-profit providers.

—The minister should have identical powers to make orders with respect to covering not-for-profit and for-profit providers—subsection 28(1).

We have an additional concern with the provision, repeated many times in different sections, that LHIN boards and organizations or health providers must make no decisions that are not in accord with the strategic plan being prepared by the Minister of Health. Others have just spoken to the same concern. That plan is not public. We are then in effect being asked to comment on the means to an unknown end. Another way of saying this is that, with Bill 36, we're being asked to buy—and I don't mean to be insulting—a pig in a poke.

So our recommendation 4 is to amend Bill 36 to include explicit parameters for public engagement in the development of the ministry's strategic plan, including the requirement to include seniors' groups.

We go on raising concerns that others have raised. We welcome the inclusion of a section called "Community engagement," but we're not at all sure when and by what means such engagement will be allowed. We note that holding open board meetings is an excellent first step, but it is qualified in the legislation. It talks about "reasonable" notice of board and committee meetings.

So our recommendation 5 says to amend Bill 36 to include explicit parameters for public engagement for each LHIN, including the requirements to include seniors' groups.

We welcome the return to community control of the community care access centres. Again, it is not clear how this will take place and it is over a long period of time.

The legislation makes clear that we're not to expect any provision under the "Community engagement" section to be actualized until at least a year after the legislation has been enacted.

In recommendation 6, we are saying to amend Bill 36 to include an appeal process, accessible or available to the community, if the community is not satisfied with a decision made by each LHIN. The second part: Provide for a dispute resolution process when LHINs and the ministry cannot agree on an accountability agreement.

Then we turn to funding, which is the foundation of policy-making. Government policy is made effective by funding decisions. We use as an example one that has really affected seniors across the province: home care. The previous government gave responsibility to the community care access centres to provide both post-hospital care and supportive care for the disabled, the chronically ill and persons with age-related functional deficits. The funding provided was never adequate for the CCACs to carry out both functions, and with patients being discharged from hospital quicker and sicker, the available resources were absorbed more and more by the needs of discharged patients who were indeed sick enough to need in-home care urgently. Supportive home care has virtually disappeared, without anyone admitting in the government that their policy was to eliminate it.

Recommendation 7: The provincial government must ensure that LHIN funding is based on the actual needs of the population. The determination of those needs must include a number of variables, such as socio-economic and health status, age distribution, the number of recent immigrants and ethnocultural diversity, and must be made in consultation with the community.

Then we turn to the issue that has again particularly affected seniors, but others as well: the experiment with competitive bidding, or mandated competition in home care. It has been a disaster for seniors. Many have seen unnecessary changes in their caregivers. We're extremely concerned that Bill 36 may give way to an expansion of competitive bidding, leading to an inefficient and chaotic system. How care is structured has a direct impact on equity of access, continuity of care and quality of services.

Recommendation 8: Amend Bill 36 to prohibit expanding the use of competitive bidding as a method for allocating funding to health service providers and ensure that any allocation process is fair and transparent.

Finally, seniors and their advocates are most concerned that Bill 36 allows the LHINs to integrate or stop service provision or potentially contract out services and allows cabinet to order contracting out of non-clinical hospital services. This bill would provide LHINs with the legislative authority to act without having to follow clear criteria and to be publicly accountable for its decisions.

Seniors are concerned that mistakes from the past are not only being repeated but are being enshrined in legislation. Seniors and others will suffer the negative impact in the form of an unstable workforce and lack of continuity in the services received, as well as worsened conditions in institutional settings.

So we come up with our last recommendation: The regulations must prohibit a LHIN from issuing decisions that order integration or contracting out of any services without clear criteria for outcomes, quality and continuity of services, criteria that balance effectiveness and efficiency. We also say that all LHINs must have the same criteria.

This is a huge undertaking, and it will succeed only to the degree that the public as well as health care providers buy into it. We therefore concentrated on three crucial questions:

(1) Will there be adequate opportunities for public input, especially for seniors, before changes are made?

(2) Will there be adequate guarantees that the system will be structured to ensure continuity of care, quality of services and equity of access?

(3) Will there be adequate funding to meet the actual needs of the people of Ontario?

Thank you very much.

The Chair: Thank you very much for your presentation. There is no time for questions. Thank you again.

1430

OLDER WOMEN'S NETWORK, PETERBOROUGH

The Chair: The next presentation is from the Older Women's Network, Peterborough chapter: Kathryn Langley and Marie Bongard. Good afternoon.

Ms. Kathryn Langley: We are from Central East. Peterborough, is experiencing a blizzard, yesterday and today. My husband was killed in a snowstorm on November 20, 2000—triage system; a big mess—so I'm afraid to drive in inclement weather. I have a car. I wanted this to be local. It isn't local. Here we are. We came by Greyhound, and thank God for Greyhound, because in our LHIN area there are very few good roads.

I'm from the Peterborough chapter of the Older Women's Network. I'm going to turn over the microphone to one of our members, Marie Bongard, who you can see is a special person.

Ms. Marie Bongard: Thanks very much, Kathryn. Speaking as an older woman with a disability, I am deeply concerned about the future of Ontario's health care. Bill 36, which will mandate LHINs, is supposed to be able to improve access to the services and make the system more efficient, but who will it benefit? I feel that too many marginalized Ontarians will have less access to service, not more.

How will people on low, fixed incomes—including working individuals on minimum wage, seniors and the disabled—be able to receive the treatment they might need? Special-needs groups do not seem to be addressed in this proposed legislation. Will they be able to find or even finance the transportation required to travel to these health centres? Will there be any allowance made for these expenses in the act?

How will someone receiving only \$536 in Ontario Works benefits be able to afford the cost of travel to some distant community for medical attention, when this allotment does not even cover their living expenses for the month? These recipients have to rely heavily on food banks for their existence.

Seniors, as they become more fragile and incapacitated, move from small, rural areas to urban centres to be closer to medical and health services. Many in our aging population have multiple medical conditions. Under the LHINs arrangement, they may have to travel in various directions to see doctors to get their needs met. Many may be just too sick to make the journey. They are another group on fixed incomes who may not be able to afford the extra cost.

Statistics show that our senior population is living longer. Although some may still drive and be relatively independent, the majority must rely on the support of others. Diseases and other medical conditions will force many of the aged to forfeit their driver's licence and independence. Seniors do not have the income to cover the cost of this travel.

I'll skip some.

Also, the cost of alternative travel will be too much for those who cannot afford it. For instance, to go from Peterborough to Oshawa is \$35. This is by Community Care, which is an agency set up for seniors and the disabled. Imagine the expense if the individual had numerous visits to more distant locations. In my case, as a blind person, I would also need assistance to find the doctor's office or area of treatment within the building itself.

Last year, I applauded the government when the ODA 2001 was replaced by the Accessibility for Ontarians with Disabilities Act. This bill was designed to make Ontario a barrier-free society by preventing and removing barriers. When barriers are eliminated for the disabled, everyone benefits. The proposed Bill 36 has the potential to create new and disastrous barriers for marginalized Ontarians. It will simply place undue hardship on the people who can least afford the cost of travel and the expense of services no longer covered by public health.

I will just say that I feel the bottom line will be that thousands of Ontarians will no longer have access to health care because they may not be able to afford it or have any means of receiving treatment.

Anyway, you can read the rest.

Ms. Langley: Thank you. The Peterborough chapter of the Older Women's Network represents women between 40 and 88 of different socio-economic backgrounds. Our membership is quite diverse. We value social and economic justice and community.

Several aspects of Bill 36 trouble us. The restructuring and structural adjustments seem suspiciously like the structural adjustments so praised by the International Monetary Fund, the World Trade Organization and the World Bank and greatly valued by the Canadian Council of Chief Executives because of the profits to be made at

the expense of workers and providers. Structural adjustments widen the already growing rich-poor gap in Ontario and favour the already well-to-do.

Bill 36 appears to give the health minister strong powers to close, amalgamate, redefine functionality and deal arbitrarily with publicly operated service providers. These powers do not extend to making the same changes with private providers. Thus, Bill 36 seems to be a vehicle promoting more privatization of our health care system. The Older Women's Network is concerned about a corporate power grab of our health care system and public services.

We're most concerned about the competitive bidding or lobbying. We question the wisdom of the competitive bidding process because it's well known that corporations have many more assets which can be used for lobbying than the non-profits. The result will be the decimation of the not-for-profit sector, in my opinion done on purpose.

In Peterborough last week, the public was denied access to the bidding information, arguably to protect the private interests. The bids were for moving from our old hospital to our new hospital. If the bids are in order, why the secrecy? Why could the public sector not have the resources to move equipment and people, since there are probably going to be so many hospitals moved in the next four or five years? Why do we need the private sector involved? A recent television show featured a bid being awarded to the offer that was winned, dined and companioned the best. We're concerned about competitive bidding.

We question public dollars for private profits. We feel that the public not-for-profit can provide better services at lower costs because ever-increasing profits and responsibilities to shareholders do not have to be factored in. We're worried about accessibility and the arbitrary boundaries. What about the people who live in the far corners who actually live closer to larger centres that may be a few miles away as opposed to travelling to the other side of their LHINs? We're worried about communication costs: long-distance telephones and messaging services. We're worried about travelling expenses.

My idea of "local" is that when I was 12, I could bike over to visit my grandfather in the hospital and play cribbage with him. My granny could walk over. My grandfather recovered from his operations. That's my idea of local. At the start of my paper, I said "local" was when I was 10 and tripped on my nightgown and fell down the stairs, and when my doctor was phoned he said to my mom, "Apply pressure and ice cubes." She says, "Oh, Dr. Ralph, I defrosted the refrigerator this morning." At 2 in the morning, Dr. Ralph arrived in his PJs and his robe, carrying ice cube trays, adjusted my nose, gave me a pill and said, "If there are any problems, come on over tomorrow." His office was five blocks away. That's my idea of local.

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Back to the Older Women's Network. We're worried about cancellations for inclement weather. We are here

today because a Greyhound was leaving at the right time. I would have been terrified to drive. Who pays for cancelled appointments? Doctors' offices in Peterborough say, "All missed appointments will be charged for." Who's going to take into account ice storms and bad weather?

Forced mergers and amalgamations: It was a disaster with the city of Kawartha Lakes and with the Kawartha Pine Ridge District School Board. It was the lowest common denominator, not an improvement at all. There were increased communication costs, distances. It was problematic for accessing personnel services and resources, doing workshops. The distances wasted time, damaged the environment, caused needless stress and increased expenses for travel and communications.

We value, as I said earlier, the common good and the community as a counter to the greed and individualism of the neo-liberal corporate globalization. We're worried about the workers. Quite a few are older women in our communities. People are being asked to work harder for longer hours or they're being asked to work fewer hours. The people in our long-term-care facilities are asked to change their eating, bathing and daily habits and have fewer activities because money is not forthcoming. "Fair-haven Forced to Make Cuts"—that was in this weekend's Peterborough Examiner.

We worry about the people in our community. People who are making good wages, with job security and good pensions to look forward to, can contribute to the life of their communities. People who are making minimum wage—it just doesn't work. We need a healthy balance between private and public, with essential services being publicly provided, not for profit, and paid for through reasonable taxation. We don't need the profit motive in there.

We don't need more delisting. Delisted services are less protected under the Canada Health Act. We don't need more contracting out. We have a good public service sector.

My idea of democracy is not LHINs boards being appointed by cabinet rather than being elected. Brampton presented you with a really good idea for community advisory groups last week.

Funding: Don't throw more money at it. It's how you spend it, and it shouldn't be for profit. The money for health should be spent on health, not large corporations.

We're worried about power in the community. We need more women's health care centres, where we have personal well-being, preventive measures, support groups, exercise groups, nutrition workshops, access to resources and places where citizens can come together, regardless of socio-economic status or ability to pay. We need more funding for community-based—and I mean local—health initiatives.

You know about poverty and social determinants of health, so as the standing committee on social policy, you must recognize the effects of increased poverty, food insecurity and housing insecurity.

We do have some alternatives suggested. We'd like to see the Canada Health Act strengthened. How about a

national dental health plan? How about a national pharmacare plan?

Errors of omission in Bill 36: We know what Minister of Health George Smitherman says, but we'd feel better having it spelled out. Where does Bill 36 say that it won't open the door to privatization and two-tier health care? Where does it say it won't close hospitals? Where does it say it won't extend the competitive bidding model to the entire public health care system? Where does it say it won't result in patients having to travel further for services, and where does Bill 36 say that it won't mean lost jobs and lower wages?

Life as we know it: David Suzuki explains in the film *Suzuki Says* that we are the environment. We are the air, every breath we take, the water—think about it: 75% of our bodies might be water—the earth, the fire. Together we are life. Everything we do has an effect on everything else. I urge you, the committee, to put the people of Ontario and their lives, their environment, their health ahead of the health of private and corporate interests. Reconsider Bill 36 and its effects, and amend it to protect our local, public, not-for-profit health care in Ontario.

Thanks. I appreciate your letting me finish.

The Chair: Thank you. There's no time for questioning, but we thank you for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1332

The Chair: The next presentation is from the Canadian Union of Public Employees, CUPE Local 1332, Espanola. It's a teleconference. Colette Proctor, are you there? Good afternoon. You can start your presentation, please.

Ms. Colette Proctor: Thank you. Hi. My name is Colette Proctor and I'm the president of CUPE Local 1332. We represent the service employees at the Espanola General Hospital and the Manitoulin Health Centre.

First of all, I'd like to say that we are very concerned that the LHINs do not include the doctors. Physician services are a major part of health care and they should not be excluded. Another concern we have is the vast areas that the LHINs cover. The LHIN boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local. They are not based on communities and they do not represent communities of interest. The North East LHIN, or LHIN 13, the one we're a part of, goes from Peawanuk in the north to South Algonquin to the south. The North East LHIN's boundaries include the districts of Nipissing, Parry Sound, Sudbury, Algoma and Cochrane. The North East LHIN also includes the eastern portion of the district of Kenora. Just to give you an idea of how far these areas are, it's at least a four-hour drive to Timmins on Highway 144, one of the worst highways you could drive in the north, and it's not a highway that you want to drive in the winter if you don't have to. So you can see that it

would be very difficult for the people living within the LHIN to have a significant voice in the direction of that LHIN, even if the LHIN board wishes to listen to them.

The autonomy of the LHIN from the government is very modest. With this bill, cabinet may create, amalgamate and dissolve a LHIN. The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose one, even if the LHIN does not agree with the agreement. In addition, the LHIN's integration plan must fit the provincial strategic plan. So the LHIN boards will be responsible to the provincial government rather than to the local communities. This is in contrast to a long history of health care and social service organizations in Ontario, which, as a rule, are not appointed by the provincial government. For example, hospital boards are not appointed by the provincial government. They have doggedly pointed out the need for better health care in their communities, with significant success. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were reversed and the hospitals were allowed to continue to provide decent, if still underfunded, care.

Recently, however, the government has found a way to blend criticism of underfunding and privatization. The key was to replace community boards with government-controlled boards. This, unfortunately, is the model for LHINs. The result of this experiment in community care access centres suggests this is a very poor model for LHINs to follow. CCACs were taken over by the provincial government in 2001. CCACs immediately ceased pointing out to the public their need for adequate funding. The result: Their funding was flatlined for years and home care services were cut back dramatically. Tens of thousands of the frail elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 1, 2001, to April 1, 2003, and a cut of 6 million hours in services—a 30% drop.

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As one government report calmly noted, as prices went up and the funding levels remained constant, CCACs had to discontinue certain services in order to maintain balanced budgets. These changes occurred independently, without provincial coordination and clear communication. The emphasis shifted from homemaking services to the provision of personal support.

My 94-year-old mother, who suffered from congestive heart failure and venous ulcers and was on constant oxygen, was allowed four hours a day, three times a week, of home care services when the VON, a not-for-profit provider, supplied the home care services. Once home care was put up for bids and Bayshore took over—Bayshore is a for-profit health care provider—my mother's home care was cut to 45 minutes twice a week. If not for the fact that her family lived in Espanola, she

would not have been able to remain at home. What happens to seniors without family support? They end up being admitted to hospital, where the cost of looking after them is much higher than home care. Government-controlled regional agencies are a poor model for health care and social service reform, if this is what we are facing.

The large, socially diverse areas covered by the LHINs also suggest that there will be significant conflict over resource allocation. What services will the LHIN provide in each area of the LHIN? Unlike government, LHINs will not be able to increase revenue. Smaller communities may be the first to see their services integrated into other communities. Espanola and Manitoulin, being part of a smaller community, will see service cuts. We're very sure of that. We already have to travel to a larger centre for some services. It's an hour to Sudbury from Espanola; it's an hour and a half to Sudbury from Manitoulin. If we lose the services we have, such as chemotherapy, we will spend hours travelling back and forth. What happens to the seniors who can't drive or the families who don't even have a car? Do they go without treatment? How do they get to where the treatment is? What happens to the people who are too frail and too sick to travel? What do we say to them, "Sorry, can't help you. We don't have the service here"?

Espanola, as I said, is an hour from Sudbury Regional Hospital. The next-nearest major centre is two and a half hours away in good weather. If services are moved, will we be expected to travel five hours to see a specialist? This is the north, and the weather is not very predictable up here.

The LHIN structure puts up significant barriers to local community control of health care. Conflicts between communities within a single LHIN are likely, with small communities particularly threatened. The provincial government will likely respond to complaints by stating, "It's not our decision. It's the decision of the LHINs," yet the LHINs will be largely unaccountable to local communities. These serious problems suggest that another direction must be investigated.

We need to provide for the democratic election of LHIN directors by all residents in the LHIN's geographic area, with selection of the chair and vice-chair by the elected directors. Local members of provincial Parliament should be ex officio directors of the LHIN. There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect a real community of health care interests so local communities can have a real impact on their LHIN's decisions. We also need a requirement for real public consultation when government proposes to amalgamate, dissolve or divide a LHIN.

We need a ministerial obligation to meaningfully and fully consult the community prior to imposing an accountability agreement on a LHIN. We need a requirement that each LHIN must establish a health sector employee advisory committee, made up of union rep-

resentatives and representatives of non-unionized employees. We need to eliminate cabinet authority to enact regulations closing LHIN meetings to the public. We need to ensure the right to seek reconsideration and full judicial review by any affected person, including trade unions, of any LHIN, ministerial or cabinet decisions or regulations.

Bill 36 gives LHINs and the government a wide range of tools to restructure health care organizations. First of all, the LHINs have the funding power to facilitate consolidation. They also have accountability agreements with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and the cabinet to force consolidation. LHINs are given the power to issue compulsory integration decisions requiring health care providers to cease providing a service or to transfer a service. The bill gives the minister even more power to order integration directly.

The bill allows cabinet to order any public hospital to cease performing any "non-clinical service" and to transfer it to another organization. This means that the government can centrally dictate how all non-clinical services are to be provided by the hospitals, including through privatization. The bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the act of non-clinical services, so this definition may be a matter of considerable controversy.

The government refers to restructuring as integration, stating that the goal is the creation of seamless care and a true health care system. But this is misleading. The LHIN restructuring will not unite hospitals, homes, doctors, laboratories, home care providers and clinics, as in other provinces. Worse, the LHINs purchaser-provider model will increase competition between providers, and plans to spin off work to for-profit corporations, private clinics and regionally based support services providers will mean more fragmentation and less integration.

The government's plan is to regionalize hospital support services. With government support, dozens of hospitals across the north are planning to consolidate supply chain and office services by turning work over to a new employer, Northern Ontario Hospital Back Office Services. Likewise, with government support, 14 hospitals in the greater Toronto area plan to regionalize supply chain and office services by turning work over to another new organization, Hospital Business Services. This organization would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations, and sever roughly 20% to 25% of employees. This is a major change that may have far-ranging consequences for workers in local communities, and more such plans are in the works.

I'm one of those employees, by the way. I've worked at the Espanola General Hospital for 35 years. I work in materials management. I could all of a sudden not be working for Espanola General Hospital, my pension

would be frozen, and I would be working for somebody that I did not plan to end my career with.

Like so much of restructuring, these moves will have a major negative impact on hospital support workers, but they certainly will not create seamless care for the patient. Instead, they will create more employers and bring more for-profit corporations into health care. In many respects, it will create more fragmentation.

The hospitals insisted that an exclusive focus on support service would not satisfy the cost savings demanded by the government, that the savings would also require clinical cuts. By April 2005, the government admitted as much, with the health minister publicly calling for the centralization of hospital surgeries: "We don't need to do hip and knee surgery in 57 different hospitals." Indeed, he suggested that about 20, or a 60% cut, would be appropriate.

The minister went on to indicate that hospital specialization is the order of the day: "Each hospital in Ontario will be given an opportunity to celebrate a very special mission ... but not necessarily ... with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travelling to multiple sites for health care services. Therefore, that means now I'm travelling five hours instead of two, because now my services may be moved from Sudbury, where I need to go, to anywhere from Timmins to the Soo to North Bay.

The government has also begun to move surgeries right out of hospitals and place them in clinics. The first instance was the recent creation of the Kensington Eye Institute. This clinic in the recently closed Doctors Hospital in Toronto is supposed to remove 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries. The minister says that this is only the beginning. But the creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to so they can get their health care needs tended to.

It also raises the possibility of the establishment of for-profit surgical clinics. Indeed, when the health minister announced his interest in surgical clinics in the spring of 2005, the chosen sponsor of his speech, University of Toronto academic John Crispo, proposed private sector clinics providing two-tier care as soon as the minister sat down.

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A better solution would be to create surgical clinics in the facilities and organizations in which we already have money invested. Hospitals have the infrastructure needed to support these surgical clinics. There is no need to duplicate their human resources, stores, payroll, purchasing, cleaning, food, laboratory and other support services. Hospitals also have the resources to deal with emergencies that may occur during operations, and this would actually help advance the seamless care that this reform is supposed to create.

Consolidation of services doesn't necessarily mean cost savings. The most recent government experiments

with consolidation have been associated with increased costs. The merger and closure of hospitals directed by the Health Services Restructuring Commission in the 1990s did not lead to reduced spending on hospitals and health care. Indeed, there has been a significant increase in spending, and many of the Health Services Restructuring Commission's directed hospital restructure projects left a shambles for exhausted and demoralized hospital staff to clean up. Sudbury Regional Hospital was one of those where phase 1 went \$140 million over budget, and that hospital still isn't finished.

The LHINs reform does not directly deal with the undisputed real health cost drivers: the soaring cost of drugs and equipment supplied by transnational corporations. Indeed, health care workers and patients will bear the brunt.

Integration will remove jobs and services from local communities, hampering access. Support services are likely the first target, but direct clinical care is also under attack. Reduction in community control and provincial government accountability will make it easier for government to implement these threats. We need fundamental change.

The Chair: Madam, you've already gone over the 15 minutes. Can you come to a conclusion, if you can? Also, if I may, could we please have a copy of your material? We don't have one. We would appreciate it if you could fax one to the clerk so she can provide a copy to all of us.

Ms. Proctor: Yes, I will.

The Chair: Thank you. Please conclude.

Ms. Proctor: In conclusion, with all these concerns, we believe this bill and the government's attempt to restructure health care needs to be rethought. We have made some suggestions on how health care reform could unfold, but we urge the government to take a considered and consolidated approach. We had no sense before the last election that the government would embark on this path it has taken. We believe the better approach would be to consult with local communities, health care workers and the public about how health care should be transformed. That would be a much more satisfactory and much more democratic process.

I'd like to thank the committee for listening to our concerns and suggestions.

The Chair: Thank you, Ms. Proctor. Have a nice evening.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Chair: We'll go to the next presentation, the Association of Municipalities of Ontario, AMO. Sir and madam, you can start any time you are ready. Could we have your names for the record, please?

Mr. Doug Reycraft: Thanks, Mr. Chairman, and good afternoon to you and to members of the committee. My name is Doug Reycraft. I'm a county councillor in Middlesex, a vice-president of the Association of Municipalities of Ontario, and chair of AMO's public

health task force. With me this afternoon is Petra Wolfbeiss, who is a senior policy adviser for AMO.

In September 2004, the Minister of Health and Long-Term Care, the Honourable George Smitherman, delivered a speech in which the province's plan to transform health care in Ontario was trumpeted. The minister stated that the government's plan included creating a comprehensive and integrated system of care that would be shaped by the active leadership of communities and driven by the needs of patients. In his speech, the minister acknowledged that transformation must begin with a new way of thinking and behaving and that the transformation would require a cultural change, driven by a genuine desire to rise above self-interest, which would be leveraged through building mature relationships.

Since the inception of the plan to transform health care in Ontario, AMO has been supportive of the government's vision of health care improvement and the intended outcomes of health service integration, namely, service efficiency, effectiveness and improved access. AMO has participated in a number of working groups involved in the health transformation undertaking, including subcommittees of the public health capacity review and the family health teams working group. The invitation to be involved in these initiatives signals to us the recognition by the government of the important leadership and expertise that municipalities bring to the table when important decisions need to be made.

AMO supports the purpose of Bill 36, but we wish to emphasize a number of points that we believe will act to strengthen the intent and objectives of the bill and the government's plan of action to achieve its vision of health transformation in our province. AMO recognizes the province's jurisdiction and exclusive responsibility for health care. In Ontario, however, communities struggle under a system that forces property tax payers to subsidize the province in the health care field. August 23, 2004, was a historic day for the maturing provincial-municipal relationship. It was the day that the current memorandum of understanding, or MOU, between the province and AMO was signed. It was on this day that the province committed to working as a partner with municipalities and recognized them as responsible orders of government. This is emphasized in the following text from the MOU:

"Effective co-operation between Ontario and municipalities enhances certainty and predictability of government performance, and promotes public confidence and sound planning.... Ontario recognizes municipalities as responsible and accountable governments with respect to matters within their jurisdiction.... Ontario and municipalities share a common goal of ensuring a clear understanding of responsibility so that Ontario and municipalities are accountable for specific policies and effective performance of their respective roles."

Given that the MOU recognizes municipalities as an order of government that is accountable and responsible, it's not clear why Bill 36 does not contain specific reference to engagement with municipalities. The proposed

legislation provides the means and objectives of achieving integration of health services and delivery at the local level. Decisions will be made that require municipalities, which are accountable to their communities and which are funders and providers of health care services, to be directly involved in the process. It is precisely, as the Minister of Municipal Affairs and Housing indicated, where the active leadership of communities through municipalities is required.

By now, the province has heard about AMO's position on the current \$3-billion gap, which is the imbalance between what municipalities pay for provincial health and social services and the funding that municipalities receive from the province for those services. It is an imbalance that makes the efforts of municipal governments to create and provide healthy and sustainable communities virtually unachievable. AMO has had a long-standing position that health services should not be funded through the property tax base. AMO also continues to hold our long-standing principle of pay-for-say. As long as municipalities are funding provincial services, they must have a say in the governance and the delivery of those services. The signing of the MOU in August 2004 and the Premier's continued recognition of involvement of municipalities in policy and program decisions at both the provincial and federal levels is a testament to our principle.

Bill 36 contradicts the current provincial-municipal context of policy and program development, design and implementation. However, while AMO is advocating for the inclusion of municipalities in Bill 36 on discussion, decisions and actions of health services program integration that have a direct bearing on municipalities on a matter of principle, it must be noted that AMO's fundamental position is that health services, including land ambulance and public health, should be funded by the province.

In short, although AMO is advocating that Bill 36 adhere to the principles of the MOU, true integrity of an efficient, effective and integrated delivery of health care services can only be achieved with the upload of health services funding, including public health and land ambulance, to the province.

Given the scope and the magnitude of the health transformation and integration of services under Bill 36, the need for core oversight mechanisms is recognized and supported. AMO has a number of comments and recommendations that can strengthen this effort. We recognize that Bill 36 does have a number of accountability provisions in place, including the consultation processes, accountability agreements and the duties of the LHIN boards of directors. Unfortunately, special-purpose bodies, as the LHIN boards are, are accountable neither to the communities they serve nor to the service providers in a community. What is lost in this model is an understanding of the integration and coordination that has already taken place at the local level of not only health care services but services between social assistance, social housing, child care and health, all of which

are funded and managed, at least partly, by municipalities. It is recommended that both the LHIN boards and the minister take into consideration local service delivery initiatives in any integration decisions, this being accomplished through open, transparent and timely engagement of municipalities.

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Each LHIN board will be required to develop an integrated health service plan that will include the "vision, priorities and strategic directions for the local health system and shall set out strategies to integrate the local health system in order to achieve the purpose of this act." It says that in subsection 15(2). The integrated health service plans will need to reflect the vision, principles and strategic direction of the provincial strategic plan for the health system. While AMO is supportive of the integration objectives, it must be reiterated that the provincial vision must not discount local realities and the good work that municipalities have carried out in the integration and coordination of local services that meet local needs.

Due to the fact that the LHIN boundaries are not aligned with municipal boundaries, the issues of governance and integration decisions will be even further complicated, and this raises many questions on municipal funding, governance and accountability. Municipal governments are accountable to the local taxpayer for the funds raised through property taxes and fees. How will the LHINs, as special-purpose bodies not accountable to the local residents, make informed and balanced decisions that truly address community needs without consistent and transparent municipal input? How will integration decisions across municipalities be fairly and equitably negotiated? Bill 36 fails to address this.

Municipalities are currently investing in hospitals and long-term-care facilities across the province and municipalities are already involved in the governance of land ambulance services and public health. Additionally, municipalities make enormous investments in infrastructure and promotion to foster economic development within their communities. Given these considerations, it seems counterintuitive that LHIN boards can make unilateral decisions with significant impacts on all of these areas. Therefore, AMO recommends that the legislation be amended to provide for municipal representation on LHIN boards.

Under Bill 36, LHINs have the authority and the responsibility, along with health service providers, to identify opportunities for integration to achieve the objectives of Bill 36. Section 26 of the bill outlines the ability for LHINs to change the scope, location and level of services of a health service provider. This then includes the LHINs' authority to adjust funding to services based on the integration plans and agreements. LHINs do not have the authority for a final decision on the integration of services. This authority appears to be granted to the minister under section 28 of the bill.

There are a number of issues that arise from the above. Most clear is the lack of municipal involvement in the

overall decision-making for a service that is funded by municipalities, specifically municipally operated long-term-care facilities and elderly person centres. It's difficult to reconcile the sweeping authority granted both to the LHINs and the minister to make decisions of service integration and funding that can result in significant exposure to municipalities regarding mortgages or other financial obligations. Why would special-purpose bodies, the LHIN boards, be given the authority to decide on issues of municipal governance and funding? Why does the minister have such broad powers on issues of municipal governance and funding, when clearly the current provincial-municipal relationship under the MOU legislates against this? Bill 36 should reflect the principles of consultation of the Ontario-AMO memorandum of understanding, and Bill 36 must consider and provide for the potential of municipal exposure arising from integration decisions.

AMO is also concerned that a final integration decision made by the minister can only be appealed through the Superior Court of Justice. Though Bill 36 contains a 30-day time frame for those affected by an integration decision to appeal, providing the legal system as the only recourse contradicts the spirit of the minister's comments made in September 2004 that the transformation of Ontario's health care system would require a cultural change driven by a genuine desire to rise above self-interest, which would be leveraged through building mature relationships.

Finally, and with great emphasis, the principle of pay-for-say is clearly rejected in Bill 36. Concern has been expressed that Bill 36 will create a dynamic of the survival of the fittest that will set the stage for not-for-profit and smaller providers competing for funding against for-profit organizations, hospitals and other more robust services. This can create an atmosphere of unfair advantage and, ultimately, decrease consumer choice. It must be decided, if Bill 36 is committed to the objectives identified in its purpose, whether some interests will be better served than others.

The government has demonstrated its commitment to improving long-term-care services in Ontario, including recognition of increased funding and ensuring equity in funding across providers. Not-for-profit long-term-care homes will be responsible to and will receive their funding from the LHIN boards, while for-profit providers will continue to receive funding from the province. AMO would like assurance that funding will continue to be equitable under this new arrangement. Consumer choice is an important right, and changes in cost-sharing arrangements potentially resulting in lower co-payments for one sector can have a negative impact on this right.

The government has lauded municipalities as leaders in long-term care services. Why then does Bill 36 not reflect this? Municipalities are ultimately excluded from decision-making on a service they fund and that reflects the needs and sensitivities of their communities. As long as municipalities fund and provide long-term-care services, they should have a say. This applies equally to

health services that may be affected by integration systems related to hospitals.

AMO supports PAIRO, the Professional Association of Internes and Residents of Ontario, and the NOW Alliance in their efforts to address doctor shortages in rural, northern and remote communities. This issue, if no other, speaks to access concerns in health care services. If you consider what has happened since the introduction of regional school boards, with the increased closure and threats of closure of schools in rural, northern and remote communities, you can understand our concern regarding the LHIN boards and the prospect of hospital closures resulting from integration. We are concerned, given the geographic scope of the LHINs, that we will see the same consequences with hospitals in rural, northern and remote communities. In fact, we're aware that this has been the fallout of regionalization of health in some other provinces. Hospitals and schools are vital factors in communities. Hospital closures, as school closures, dramatically impact the viability, health and sustainability of a community.

Mr. Chairman, there are a few other comments included in the brief here. I realize from your signals that we're nearing the end of our allocated time, so I'll stop at that point with our presentation.

The Chair: We went just over, but that's fine. We do have the material here. Thank you for your presentation.

ONTARIO PEER DEVELOPMENT INITIATIVE

The Chair: The next presentation is from the Ontario Peer Development Initiative. Good afternoon, sir. You can start any time you're ready. There are 15 minutes total.

Mr. Shawn Lauzon: I shouldn't be that long. My name is Shawn Lauzon, I'm the executive director of the Ontario Peer Development Initiative. I'd like to just read a quote from one of our member organizations, as we try to have an open consultative process to respond to this bill: "A patient-centred health care system can only be realized with defined engagement with people who have first-hand experience of the mental health care system."

I come to you not only as an individual bringing the voice of the consumer/survivors in Ontario, people who have used the mental health system, but also as a person who has used mental health services in Ontario.

The Ontario Peer Development Initiative is a provincial voice representing 51 community mental health programs throughout Ontario. They are run by, and on behalf of, people who have had or continue to have direct experience with using mental health services. These programs are also known as consumer/survivor initiatives, peer support programs and community economic development programs.

OPDI speaks collectively for consumer-run mental health programs and organizations that in turn represent consumer/survivors. We support a health care system that is based on having access to services and supports close

to their communities, which will improve the individual's overall quality of life. As well, OPDI shares the common belief that recovery from mental illness is possible. We speak from a unique position as both mental health consumers and as health care providers. Through our collective experiential knowledge and evidence-based research, we shape what we offer: a wellness-oriented approach.

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The positions we are presenting to you today are based on a year-long consultation process with our member affiliates. They include a June 2005 annual general meeting, with 60 participants attending information sessions, with questions and answers, with regard to the LHINs. In November 2005, at our Creative Directions annual conference, we had 97 delegates from all over the province, with two presentations and more facilitated discussions with our member affiliates. In January 2006, we completed this by providing a membership survey to 51 organizations, and elicited further feedback for the drafts we present to you today.

The potential of local health integration networks under Bill 36: "The purpose of this act is to provide for an integrated health system to improve the health of Ontarians through better access to health services, co-ordinated health care and effective and efficient management of the health system at the local level by local health integration networks."

The Ontario Peer Development Initiative supports the intent of Bill 36 and the development of LHINs, as it speaks to us as health care users. We do want better access to health care services that are coordinated. We do want those services to be delivered at the local level wherever possible. We do want a system that, by becoming more effective and efficient, is easier for us to navigate.

The Ontario Peer Development Initiative supports the intent of Bill 36, as it speaks to us as health care providers. We collaborated recently with other mental health sector stakeholders in a report called *Consumer/Survivor Initiatives: Impact, Outcomes and Effectiveness*, which reported the impacts and outcomes of consumer/survivor initiatives in Ontario. This report was mailed to each of the MPPs last fall.

In that context, the mental health programs we offer are already fulfilling the proposed goals and outcomes of the LHINs. We offer a sampling of quotes from the paper:

"CSIs represent a way to both ease and enable people's transition from formal mental health services back into the community."

"CSIs contribute to reductions in the use and cost of services—including community mental health programs, hospitals, psychiatrists, and general practitioners, income support programs and other services—funded by the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services."

"Participation in consumer/survivor initiatives reduces hospital use."

The report documents how innovative approaches, community partnerships and evidence-based research, funded by the ministry, show the leveraged value of the services and supports we offer to hard-to-reach populations.

OPDI's concerns with Bill 36: The legislation lacks clarity. I will quote from the member surveys throughout in dealing with the concerns, as per the following quote: "It's all very difficult to understand." This legislation proposes to create a great deal of change and is stated in a complex and vague way. Our recommendation is that this legislation needs specific details, and in plain language.

Community engagement is not defined. As per some quotes from member surveys: "How will the process of community engagement be fully inclusive, valid and consistent province-wide?" "The extent of community engagement may be a hit-and-miss process depending on the staff hired."

There is no definition of community engagement. The framework of the legislation does not spell out how health care consumers like us will play a specific role in a patient-centred system of care. Our recommendation is that the definition of "community engagement" should be stated clearly and affirm a role for the users of the health care system.

LHINs need to be proactive in considering the needs of people and the agencies they are intended to consult with: "Policies and procedures put in place reflect needs of larger agencies." "Traveling distances makes the community consultation process difficult."

LHINs cover large distances. Community consultation involves travelling expenses and the attendance of representatives. Our organizations' consumer/survivor initiatives are stretched for both resources and staff time. Previous LHIN consultations did not support resources needed by consumer-run mental health programs and organizations. Many of our affiliates were not able to attend those.

Our recommendation: LHINs must be responsive in their community consultations to the needs of smaller organizations and be accessible to populations with special needs. As a consumer, and going to one of those consultations, I know it was very overwhelming for me. In seeing some people with physical disabilities, I could see how they were very much overwhelmed as well.

Governance and funding for organizations are not defined. "If this money is transferred to the community, then there is no commitment that it will be protected as part of the mental health funding envelope or even that a consumer/survivor initiative will deliver these supports, or that the money will be set aside to continue these types of needed supports."

As the oft-described orphan of the health care system, mental health funding needs to be protected and expanded. Investing resources in organizations that work within a wellness-based approach is a wise choice. Keeping people out of hospital and minimizing the long-term use of traditional service providers are stated

outcomes of the health care transformation agenda. OPDI has long maintained the position that 5% of all community mental health budgets should be allocated to consumer-run programs or organizations.

Our recommendation: Bill 36 should include mental health explicitly as part of the health care system and ensure adequate funding for consumer-run mental health programs and organizations.

Consumer-run mental health programs and organizations reflect the personal and collective empowerment of individuals. These programs and organizations serve as a complement to the broader health care system. The high degree of membership involvement in decision-making and in the governance of the agency echoes the empowerment and self-directed values grounded in personal choices leading to recovery.

Our recommendation: Consumer-run mental health programs and organizations require autonomy.

Decisions made by LHINs and the ministry must reflect evidence-based best practices. "Operating efficiencies can be justified economically, but 'bigger is better' does not apply to mental health consumers who require tailored services for specific needs and based in their own communities."

Evidence-based research confirms the leveraged value of consumer staff, known as peer support workers, collaborating with mental health professionals in the institutional setting and in the community programs.

Our recommendation: Investment in research, education and training is required to promote best practices of consumer-run mental health programs and organizations.

Thank you very much.

The Chair: There is about a minute left. The last time, I recognized the government, so to the opposition. Only one minute, please.

Mr. Arnott: Thank you very much for your presentation. We've heard a lot of concern about the lack of explanation by the government as to how community engagement is going to work. I've asked this question to another group today, and I would ask you the same thing: What should be the guiding principles, as far as you and your organization are concerned, of how that should work?

Mr. Lauzon: I've heard we're supposed to have a patient-centred system, and I feel it's really necessary to start with the patient first in all respects of the health care system. That kind of consultation should lead the way to the LHINs' development and their understanding of how to proceed with consultation to the service providers and other stakeholders in their community.

I do believe that it should be the person first. If we're looking at having a system-wide response to people's needs, then we have to really clearly see what people's needs are in every part of their lives, not just physical health care, but down to the person using mental health services.

The Chair: Thank you very much for your presentation.

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SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0N

The Chair: Next is a teleconference from Donna Lehman, Service Employees International Union Local 1.0n. Ms. Lehman, are you there?

Ms. Donna Lehman: Yes, I am.

The Chair: Would you please start your presentation? You have 15 minutes in total.

Ms. Lehman: Good afternoon, Mr. Chair and committee members. My name is Donna Lehman, and I am a support services worker at my local hospital, Bingham Memorial, in Matheson, Ontario.

Matheson is a small community about 40 kilometres south of Timmins. I live in a rural community in northern Ontario, and our hospital serves at least three other smaller communities, along with a reserve to the east of us and mines within our district.

I am speaking to you today because of the concern to my family and the families of our communities who depend on our local health care services. I would like to feel assured that the health care services now being provided locally do not deteriorate or lessen because we are put into a large LHIN area. We have gone through one hospital amalgamation in our area, which meant cuts to some of our local services, and also to the care given because of heavier workloads with fewer health care providers and support workers.

Health Minister George Smitherman has said that no hospital will close as a result of this legislation. What he has not committed to is whether hospital services in smaller communities like mine will be downgraded to walk-in clinics or be converted into nursing facilities or long-term-care centres. The health minister also said, in his opening remarks to these committee hearings, "In an environment where we all agree there will be fewer resources than we might prefer, it's just common sense that we ask people from local communities to help determine which local priorities must be supported first."

My LHIN, LHIN 13, the North East LHIN, stretches from North Bay to James Bay. It stretches from the Quebec border on the east to Lake Superior on the west. It includes Manitoulin Island, the cities of Sault Ste. Marie, Sudbury and Timmins. This LHIN includes 34 hospitals, 48 long-term-care centres, 40 mental health facilities and organizations, 30 addiction treatment centres, four children's treatment centres, six community care access centres, three community health centres, and 75 community support service organizations. Geographically, the LHIN carries an area as large as western Europe.

Our LHIN, like every other LHIN, will have a board of directors comprising nine unelected Liberal government appointees who, at this point, if not nameless, are totally faceless to the citizens of this LHIN.

Section 26 of Bill 36 allows a LHIN enormous power to cease any health service, transfer any service, or integrate any service. With the vast geographic area of

LHIN 13 and many services and facilities within the LHIN, it appears that this LHIN is ripe for any integration plans the Minister of Health may have, but what on earth is local about this LHIN? The community of Little Current on Manitoulin Island has as little to do with Moosonee or Wawa or Kapuskasing as the price of gasoline in China has to do with a person filling up the tank of his snowmobile in Kirkland Lake.

That this legislation will give greater control to local communities is just plain false. This legislation is all about giving greater control over health care to the Minister of Health and the Ontario cabinet.

What chance does a small community like Matheson have against the larger communities such as North Bay, Sudbury, Sault Ste. Marie and Timmins in this vast geographical expanse? Section 16 of Bill 36 states that the LHIN is to engage the community. For the North East LHIN, there is no way that decisions could be carried out in any democratic way. What community interests are to be taken into account, and to what degree?

Reconsideration of LHIN decisions only allow an affected party 30 days to appeal. This is a very short time frame for any party to make a submission for reconsideration or to study the impact of a LHIN decision. Anyone wanting to appeal a decision would, I assume, need to travel the LHIN administration location to submit an appeal. What citizen in the North East LHIN could drive more than six hours over icy roads to make an appeal to save a specific health service in a small community?

I really want this committee and the health minister to understand that under this legislation, the communities of Gogama or Chapleau will have no local input into what type of health care will be available in their communities. The size of our proposed LHIN area for northeastern Ontario worries us. Services we have and need will be amalgamated, transferred or merged to a larger centre, leaving patients in small communities such as ours travelling long distances—anywhere from four to six hours, depending on the weather conditions—to receive care for a health service they require. This will prove to be a hardship on the sick and elderly in our communities, who have most services available to them locally, along with the support network they need at a time such as this.

Communities should have services available to them close to home. Patients deserve the services within their communities to enable them to be close to their families and friends. It seems this legislation does not focus on the patient, but rather on how to save money by consolidating, amalgamating and privatizing health services.

The public needs to have a voice in how this legislation will affect them: the large areas to be covered by the 14 LHINs. Why are these decisions being made for them without their input? Health care should be accessible to the public locally, within their communities, and should not ration patient care to save money.

As a health care worker, I am also concerned about what Bill 36 will do to my job. I have already said that in our area, we have been subjected to one hospital amal-

gamation. Bill 36 will further exacerbate that. The Minister of Health or a LHIN must not have the power to transfer a public service to a for-profit operator. Competitive bidding must not enter into the hospital sector to drive down wages or eliminate jobs.

I earn about \$32,000 per year. It is not very much money to live on in northern Ontario, yet as a hospital worker, up to now I have been fortunate to keep my job when many in the resource sectors of the economy are losing theirs. No form of competitive bidding for our jobs must be allowed. Non-clinical service positions such as mine are vital to the quality of the health care system. We ensure the highest standards of cleanliness. We will not go the way of British Columbia health care workers, who lost their pensions and their benefits and now work for \$13 an hour. It is not right that health care workers paying the new McGuinty health tax deserve to carry the burden of a government determined to balance its budget on our backs. Public health care dollars must not go to for-profit companies.

Thank you for the opportunity of making this presentation.

The Chair: Thank you. We have about a minute each for questioning. I will start with Ms. Martel.

Ms. Martel: Thank you, Ms. Lehman, for joining us in Matheson today. I live in your LHIN too, but you are about four hours away from me in my LHIN, and that's not even covering half the north-south distance of the entire LHIN; I live just a little bit north of Sudbury.

Folks from our part of the world, when they hear "amalgamation" or "integration," think what's going to result is that essentially the bigger hospitals in North Bay, Timmins, Sault Ste. Marie or the regional centre in Sudbury are going to get even more services, at the expense of small community hospitals like yours. I'm glad you raised the point today that, as someone from Matheson, you're concerned about that.

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Folks from Matheson already travel to Timmins now for a number of services. If we see some of those services now offered in Timmins transferred to the regional hospital in Sudbury, what is that going to mean for folks who now access services either at your own local hospital, which is right in the community, or already have to travel at least an hour to get to Timmins? What's it going to mean for all those people who are seeing a service in their own community hospital amalgamated or transferred to or integrated somewhere else? What's that going to mean in terms of them travelling? What's it going to mean for their health care and support services, which they really want as close to home as possible?

Ms. Lehman: A lot of them won't be able to travel that far. It's going to be hard on them.

Ms. Martel: Are you concerned about what that's going to do to their own health care?

Ms. Lehman: Their own health care. How will they be able to get to their appointments? A lot of people in smaller communities don't even drive. Getting to Timmins is hard enough, but to get to Sudbury or somewhere else would be even harder.

The Chair: Ms. Wynne.

Ms. Wynne: Hi, it's Kathleen Wynne. I just wanted to make a comment. It seems to me that right now, where you are in Matheson, all the decisions about health care that for the most part will be made by the LHINs are being made now in Toronto. It's like we have one great big health decision-making body, and that covers the whole province.

Our thought, as the government, is that it would be way better to have some people from some of the communities away from Toronto sitting together and talking about what the gaps are, what needs to be kept in the community so people can get to those services, what could be put into a specialized hospital. It's having people who really know the areas. And not all the people on these LHIN boards will come from one community. For example, we were in Thunder Bay the other day, and of the people who have been appointed to the board, one of them came from Thunder Bay but the other five came from communities far away from Thunder Bay. We're trying to put together some people who will make decisions based on what's needed in the communities, so with luck, you won't have to travel as far for those services you need on a regular basis. Does that make some sense to you?

Ms. Lehman: So there will be people chosen from communities such as ours?

Ms. Wynne: Absolutely. That's happening now. Obviously, there won't somebody from every community in the province, but there are people being chosen not just from the big communities but from the small ones. That's one of the ideas of this.

Ms. Lehman: So how are they being chosen? Are we able to say?

Ms. Wynne: There's a public appointment process. Of the nine board members, the people on the board are being asked to identify three community members themselves. But the people who have been appointed already by the provincial government are people who are from those small communities.

Ms. Lehman: So they've already been appointed?

Ms. Wynne: Some of them have. The process isn't completed. But the point I'm trying to make is that what we're trying to do is get people from outside of Toronto making decisions about health care outside of Toronto.

The Chair: Mr. Arnott, please.

Mr. Arnott: Thank you very much, Donna. This is Ted Arnott. I'm the Conservative MPP for Waterloo-Wellington. I represent a riding that has a lot of small towns and also a part of the city of Kitchener, and I can certainly understand many of the concerns you've expressed. In our small towns in Waterloo-Wellington, we think of "local" as meaning within the same town you live in, not a vast geographical expanse the likes of which you were talking about here in terms of northeastern Ontario.

The fact that you've made this presentation is very important to this committee. I hope the government pays attention to it.

Ms. Lehman: I hope so.

Mr. Arnott: The government is telling us that they're trying to appoint members of the LHIN boards who will represent the smaller communities. Time will tell as to whether or not that is true. If our small rural communities have a strong voice, like what you've expressed today, I think there's a better chance that we're going to be heard.

The Chair: Thank you, Ms. Lehman.

GTA/905 HEALTHCARE ALLIANCE

The Chair: The next presentation is the GTA/905 Healthcare Alliance, Tariq Asmi and Kirk Corkery. Good afternoon. Thank you for coming. You can start your presentation whenever you're ready. There's 15 minutes in total.

Mr. Kirk Corkery: Thank you very much, Mr. Chair. It's good to see you again. Thank you very much, committee members, for inviting us this afternoon to present. My name is Kirk Corkery. I'm the chair of the GTA/905 Healthcare Alliance. Beside me is Tariq Asmi, who is our executive director. I believe you have our foils in front of you.

The Chair: Yes, we do. We were given a copy.

Mr. Corkery: If you wish to follow along, that may make it a little easier for you.

The GTA/905 Healthcare Alliance represents hospitals in Halton, Peel, Durham and York. These regions currently make up more than a quarter of Ontario's population. We are among Ontario's fastest-growing regions, accounting for more than half the annual population growth in Ontario.

Bill 36 is truly watershed legislation for the planning, funding and decision-making of health care services in Ontario. It's also watershed in terms of the potential impact on access to health care services in the GTA/905. The alliance is fully supportive of Ontario's move towards local health integration networks.

However, Bill 36 is also a great opportunity to make LHINs about more than transferring, merging, amalgamating and ordering health care providers to cease operating. The alliance does not believe that the transferring, merging, amalgamating and ordering of health care providers to cease operation will alone bring about a more integrated and accessible health care system. We think you can do better. Bill 36 and LHINs can also, and should foremost, be about patients—better access to health care services and better access primarily within a LHIN.

In a nutshell, our concern is about making sure that the word "local"—to MPP Wynne's immediately prior comments, the issue of local is important. It must be local. It has to be balanced with the word "integration." So while we are fully supportive of the move towards local health integration networks and will work towards making the LHINs successful, we have some concerns about Bill 36 as it's currently written because it could mean less local access.

Our concern about less local access stems from the fact that the four GTA/905 regions are among the lowest-

funded, if not the lowest-funded, regions in Ontario on a per capita basis for health care. Without this balance between local and integration, coupled with a lack of growth funding for the 905, it could mean the 905 LHINs may experience a disproportionate pressure to transfer, merge, amalgamate etc. This means that the LHINs may not result in improving access to health care services for over a quarter of Ontarians; rather, it has the potential to do just the opposite.

The amendments we offer you today would make Bill 36 more about improving population health status, maximizing local access to health care services, allocating resources on the basis of population needs, and having LHINs work on behalf of their residents. We think these are the goals that we all share.

If you'll turn to slide 5 in your handout, we'll just quickly start through a few of the recommended changes that we have. Bill 36 makes clear that to integrate means transferring, merging and amalgamating. The definition of "integrate" should also speak about improving patient care. The key foundation here is that we have to think of the patients first. So we are suggesting that it also be defined to improve the continuity of patient care, to increase health care service provider collaboration within a LHIN, and to increase the information-sharing within and across LHINs.

Slide 6: In the bill, it talks about the definition of "public interest," to do things for the benefit of the public interest, but "public interest" is never defined. On slide 6, we have defined some of the things we think should be included in the act with respect to defining the public interest. Let's not leave it undefined.

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Slide 7 talks about the objects of the LHIN. At the present time, it's talking about making decisions to transfer, merge, amalgamate. These are all wonderful things in terms of efficiency; they do not speak to patient care. We need to talk about things that are patient care. We need to talk about optimizing LHIN residents' health. We need to talk about their access to local health services. As such, we're recommending that those specific objects be included in the bill, and we've listed four there for your consideration.

In terms of slide 8, the minister has been clear that to improve the decision-making in Ontario's health system, it has to devolve to the regions. We agree. No problem with that. However, the bill does not at the present time ensure that the board members are members of the local LHIN. We think it should be enshrined in the legislation that they need to be chosen from within the community. Let's say they have to be chosen on the basis of skills. There are lots of people out there who've got the appropriate skills. Let's state that in the legislation, so that it's based on merit. Let's make sure they represent the communities they serve.

Tariq, I'll let you take the rest.

Mr. Tariq Asmi: Thank you, Kirk.

I'd like to refer to slide number 9. There are two recommendations on this slide. First, Bill 36 gives the

minister full power to allocate provincial funding based on “terms and conditions” that he or she sees fit, but really, this is only half the equation. For Ontarians who live in communities with differing characteristics, differing population sizes and rates of population growth, we believe it’s also essential that the minister is required to also fund LHINs on the basis of population size and population characteristics; that is, population-based funding.

Some of the most successful experiences with health care services regionalization across Canada make explicit use of population-based funding formulas for the regional authorities. Population-based funding is not just about meeting the health care needs of Ontarians as close to home as possible. It’s equally important in terms of equity, in terms of fairness and accountability.

In addition, we think stakeholders should know how funding is actually allocated to LHINs. Currently in Ontario’s health care system, there is no such transparency for health care funding. As such, we recommend that you amend subsection 17(1) by adding that the minister must also provide funding to a LHIN based on the health service needs of LHIN residents based on population size and population characteristics of the residents. We also think you should add a subsection that says the minister will make a document available to the public through the ministry that outlines the criteria, the formula and all the other information that we use to allocate funding to LHINs.

The second recommendation is about incenting the health care system to pursue further efficiencies. Hospitals in the GTA/905, having to do more with less, are already some of the most efficient hospitals in Ontario and perhaps Canada, and we will continue to seek out efficiencies. But right now, Bill 36 does not guarantee that some of the savings and the resources freed up through efficiencies will remain in the LHIN. Therefore we have concern about whether we will continue to incent further efficiencies within a LHIN. We think you need to amend subsection 17(2) to say that the minister shall reinvest the savings generated in a LHIN in one previous fiscal year in future fiscal years.

I now go to slide 10. Slide 10 is in terms of planning for health care services in Ontario. Bill 36 makes it quite clear that the minister’s provincial strategic plan for the health system will directly shape the integrated health services plans of the LHINs. They must be consistent with the minister’s strategic plan. Therefore, LHINs will have to issue orders to transfer, merge and amalgamate based on the minister’s strategic plan. We think we should amend section 14 to say that when the minister, he or she, develops this provincial plan, they should do it in consultation with health system users—patients and consumers—and service providers and have time to maximize local access to services within a LHIN and maximize high-quality health services.

In terms of the integrated health services plan to be prepared by LHINs, we would recommend adding a subsection that the integrated health services plan shall

plan for local access to a range of services that are prescribed by the Minister of Health that are based on the population of the LHIN and the population characteristics of that LHIN.

Slide 11 is with regard to due process. There are four criteria that make a decision ethical: You need to communicate, you need to share with the stakeholders, you need to make that public and offer an opportunity for review of appeal. We offer you several recommendations for making this section a more ethical, more accountable and transparent process when LHINs will be issuing their integration decisions.

Our last recommendation for improving Bill 36 pertains to the historic autonomy of hospital foundations. Given that foundations really are not part of the scope or the objects of LHINs, we recommend that you delete subsection 50(11) that proposes to amend the Public Hospitals Act.

I’ll now pass it back to Kirk Corkery.

Mr. Corkery: Respecting the time, I’ll make just a couple of quick concluding remarks.

We’re fully supportive of the move toward LHINs. We’ll help make it work. Our 11 hospitals are committed to making the best they can of the resources they’re given. As it’s currently written, we have a couple of concerns about local access to make sure that what is intended does in fact happen, and the suggestions we’ve made here today, we believe, will go toward that end. I ask you today to please put back into this legislation two things: the patient and the concept of “local.” Enshrine it there. If you don’t enshrine it, it will not happen.

On that note, Mr. Chair, members of the committee, thank you very much for allowing us some time to speak with you and put our ideas forward. We’re obviously open for questions.

The Chair: Thank you. We have about 30 seconds each. I’ll start with Ms. Martel.

Ms. Martel: Thank you for pointing out that, in truth, subsection 17(2) doesn’t say that savings are going to automatically go back to the LHINs. There was a discussion about that last week in the committee when I asked the Association of Community Care Access Centres about that. I’m glad to see that you have made a point of saying that it should be very specific in the legislation that those savings will be reinvested; otherwise, my concern is that the savings will just be deducted or that the overall pot will be deducted by the savings amount in the next fiscal year.

With respect to “local,” I’m looking at the amendments you’ve put forward to making sure that “local” will be highlighted. Does that cover essentially all the sections you were concerned about where there needed to be a very specific reference to ensure that access is local and services are local? Does that cover the concerns you had with respect to the bill?

Mr. Corkery: We believe that if the decision-makers on the board come from the local area, that will go a long way towards ensuring that the appropriate things happen. Care can be better delivered in your local infrastructure.

You get better faster. If your family and all the people you know are around you, you get better faster than being shipped away or having to travel greater distances.

As it currently sits today, people in Brampton or Markham or wherever—people say, “Just go to downtown Toronto.” No. That’s an hour-and-a-half taxi ride, or worse. In other parts of the province it’s an even worse situation, as you’re much more aware. At this stage of the game, we would be satisfied if initially in the legislation it ensures that the people making the decisions come from the local area. That’s the specific change we’re asking to be made. Broadly, the funding level needs to account for all the people in the LHIN. It needs to be population-based so you get funded for your health care where you live. That’s the other piece we’re asking for in the changes.

1600

Mr. Levac: Gentlemen, thanks for your presentation. You made some very smart and well-thought-out recommendations. Let’s make something clear: We’re talking about differentiating between how hospitals operate inside of the LHIN versus the LHIN having control over the hospital. Those are the two sectors. For example, the hospitals in the LHIN that I represent have already collectively decided to put a VP in charge of communication and IT, so therefore, we’re going to get those efficiencies and savings in transporting information back and forth, simply going from a doctor to a hospital to a second hospital. Those are the good things that are happening. When you say health care services, I think it’s also important to distinguish between what hospitals provide and the patient, versus the upfront hope that what LHINs do is help us get preventive enough that we will lessen the burden on the hospital structure.

You also mentioned the minister. In the legislation, I think the minister has to consider that, and you’re requesting that the savings must be poured into the local LHIN. I hope I’ve got that right.

As to population, if it doesn’t go hand-in-hand with the characteristics, I think we’ve got a major problem. We’ve got the north, but my LHIN has a notorious number of senior citizens, and we would have to design our LHIN based on that information, and that needs to be local. Am I capturing exactly what you’re trying to talk about here, for example?

Mr. Asmi: What we’re suggesting is that if it’s going to be local health integration networks, the “integration” and the “local” need to be given equal emphasis. When you fund, you fund on the basis of population needs, which is size and characteristics. So you’re bang on. As well, in any efforts to achieve savings, those who accrue the savings should receive the benefits. The notion is just making explicit in the legislation exactly what you’re saying, so when it comes to future governments, they too will abide by the intent of your legislation. Let’s put it in the legislation.

Mr. Arnott: Thank you very much for your presentation. I want to ask you a question about the point you made on page 12 of your slides, the autonomy of hospital

foundations. This is an issue that has come up in the last couple of days. I unfortunately had to step out for a minute while the Ontario Hospital Association was making their presentation, but I understand that they expressed a similar concern about whether or not hospital foundations would be able to keep the money they’ve raised as opposed to having the money redistributed by the LHIN as it sees fit. I’m wondering if you’ve had any assurance from the government that the bill is going to be amended to ensure that this will not happen.

Mr. Corkery: We have received no such assurance, sir.

Mr. Arnott: I would ask if the parliamentary assistant is in a position to speak to this, because this is a really serious concern.

Ms. Wynne: I’m not in a position to say whether or the exact nature of the amendment that will come forward, but I am in a position to say that it is being considered as something that the minister and the ministry are well aware of.

The Chair: Thank you for your presentation.

HOSPITAL FOR SICK CHILDREN, EATING DISORDER PROGRAM

The Chair: We are going to move into the next presentation, from the eating disorder program, Hospital for Sick Children. Dr. Leora Pinhas. Have a seat, doctor. Thank you for coming and joining us. You can start whenever you’re ready.

Dr. Leora Pinhas: I’m coming with a specific reason and a specific topic, which is the area of eating disorder services in this province. I don’t need to tell you that eating disorders are a very serious chronic illness that occur in children as young as five or six now and can be life-threatening; about 5% to 8% of people will die from their illness. Even though most people recover from their illness, they do require on average about five to seven years of health care services, not only to help them recover from the psychological aspects of the disorder but also to help them either recover or prevent the physical disturbances that come with this disorder. It’s not unusual for us to see children who are stunted in their growth, who have growth delay, who have osteoporosis. Osteoporosis, as you know, is an illness that happens to 80-year-olds. It’s a very poor prognosis if you’re 16 with osteoporosis and have to face a whole lifetime with that kind of morbidity.

I also want to say that over the last 10 years, the eating disorder health care providers, along with consumers across the province, have worked hard to develop an integrated provincial network that is basically built on logic and on patient demand. We have worked hard to try to develop primary care services locally across the province that then feed into more centralized, secondary, tertiary and, finally, quaternary care services.

I will give you the example of Sick Kids. We have a nine-bed in-patient unit, and we’re the only in-patient unit in the province. That already is not enough: nine

beds for all the children and adolescents in the province. I can tell you that we regularly have quite a long waiting list. However, while I do think that we need to increase this, it presents two problems.

First of all, it doesn't make sense to have an in-patient eating disorder program in every LHIN. So how do we decide where those programs will be placed? And who will take this on, as an in-patient program for eating disorders is extremely complex and expensive in terms of per capita cost?

My worry with the LHINs that don't reflect the past regional development of the network—two things. One is that for a system that is already in crisis, meaning there are people who die on the waiting list and there are numbers of people who have to be sent to the States, how will that continue to be funded when it comes up against local primary health care issues? We're talking about small numbers. Who will take that on? Also, how will the centralized services be funded if we're focusing on providing local treatment? It's impractical to provide these kinds of services locally when you're getting to the higher levels of service. For instance, if the Toronto LHIN funds the program at Sick Kids, what happens if a child from Sudbury shows up at the door? Who pays for that? It's already hard to figure out who pays for that, and we already are turning away people who require treatment.

So those are my concerns. One is a system that's already dramatically underfunded and is the orphan of medicine and psychiatry—a disorder that is increasing in numbers but also has attached to it a significant stigma. My patients aren't going to be knocking on anyone's doors, complaining. How are we going to make sure that this service continues in an integrated way?

That's it.

The Chair: Thanks very much. Ms. Wynne.

Ms. Wynne: Thank you very much for coming. We did hear about this issue earlier. One other presenter came to us and talked about this specifically. When I look at the objects, Dr. Pinhas—it's section 5(g)—one of the objects of the LHIN is "to develop strategies and to co-operate with health service providers, other local health integration networks, providers of provincial services and others to improve the integration of the provincial and local health systems and the co-ordination of health services."

That's where I would look, to one of the goals of creating LHINs to make sure that a service like this is provided. I think it's an incredibly serious issue. One of the big concerns about what goes on in the province now is that there are huge gaps, so that a kid or an older person in Toronto has way more access to an eating disorder clinic, for example, than someone who lives in another part of the province. I would see this whole process as trying to ameliorate the situation that you're dealing with, and I would see that section as being the one that specifically points to the obligation of the LHINs to do that. Can you comment on that?

Dr. Pinhas: Sure. Two things: One is that you're mistaken. In fact, an adult person in Toronto probably

has less access to out-patient services and to primary care services than someone in Barrie, and this is part of the problem. Toronto General Hospital is seen as the quaternary or tertiary care centre; all of their resources have gone to support their in-patient unit, and because of funding deficits, they actually had to close their out-patient program.

Ms. Wynne: But it's uneven. My point that it's uneven is accurate.

Dr. Pinhas: It is accurate. However, I guess my concern is that while these treatment centres are very important to us and to the people we serve, we're small potatoes compared to everything else. My sense is that this issue, unless it's protected in some way, will fall by the wayside, and the more fragmented the decision-making becomes, the more likely it is to fall by the wayside. My LHIN may think it's important, but another LHIN that happens to have fewer patients that year, when they're looking at this issue, may choose not to focus on this service.

1610

Ms. Wynne: Do you have amendment language that you're suggesting?

Dr. Pinhas: I don't.

Ms. Wynne: Okay. If there were—

Dr. Pinhas: I would be happy to forward you some suggestions, absolutely.

Ms. Wynne: That would be great. Thank you.

Mr. Arnott: On behalf of the Progressive Conservative Party of Ontario, I want to thank you for your presentation. I'm looking forward to reviewing the Hansard when we get an opportunity to do so. You've made a number of very important points.

I think you're not alone in your concern. As the government pursues this agenda of reorganizing health care, there's a great deal of concern about whether or not the new structure, the new LHINs, will see fit to carry on many of the important programs that have been funded in the past. So by coming here and speaking up about the important work that you're doing, you have a better chance of ensuring that it will carry on.

Ms. Martel: Thank you very much for your participation here today. Joanne Curran made a presentation to us from Hopewell in Ottawa, and in the question-and-answer that went on I made the point that there is no duplication in this network. In fact, the network is grossly underfunded and people within the network—I'm going to focus mainly on providers—have already made very serious decisions about allocating resources to specific hospitals, for example CHEO in Ottawa, at the expense of other hospitals and other services, to try and make the system work. So what is not needed here is a LHIN to deal with duplication; it's money—cold, hard cash—to actually make sure we can sustain the services that are in place, which are grossly underresourced right now, and provide some enhancements so we stop sending patients, 50 of them a year at least, to jurisdictions in the States for treatment, and then they come back and have no support

and they go again the next year, which is exactly what has happened in this last year.

Can you tell me, with respect to the proposal that went in from Gail McVey, was the original request for about \$20 million, and that went in in December 2004?

Dr. Pinhas: Yes.

Ms. Martel: Okay. And still we have no response from the ministry, although I do know that the group was asked to very significantly pare down that amount of money. If the network were to get a couple of million dollars—\$2 million or \$3 million—what's that going to do for patients who need services at all levels in this province?

Dr. Pinhas: Basically, \$2 million would probably help us solve some of our deficits. It's probably not going to provide any increases in services. I just want to comment that if you look at the rates of kids, and adults as well, who are going to the States, that number is actually increasing exponentially. It's not increasing in a linear fashion. Two million dollars will help us survive with what we have right now. It's certainly not going to increase our funding.

I am aware that Joanne did present here and I do also concur with her. One of the models I would like the committee to consider is the idea of having some kind of special provincially protected position for programs like this that are intense, that service a lot of people, but because they service particular parts of the community, they're small compared to other kinds of numbers. This would be the same with any kind of life-threatening illness that happens to a minority of people in the province.

You're right, there is no duplication. In fact, essentially what we do—I have to say, to the credit of the network, that we do get together as a whole province when we get these small pots of money and say, "Okay, we've got this much money. How can we best meet the needs?" The first year we got money we decided it would go to primary care. This most recent time, we're really noticing that the increase in primary care has flushed out of the communities the important need for quaternary and tertiary care. So where would we put a little bit of money? I think the province, in terms of the health care providers—the patients and their families are best situated to make that decision, but that decision needs to be viewed across the province, from a provincial perspective, not just from a local perspective.

The Chair: Thank you very much for your presentation.

The next presentation is at 5. One of the two people is present, so we're going to have maybe a five-minute break until the second person arrives, and then we will be able to end the day.

The committee recessed from 1615 to 1622.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair: We are all—oops, we lost the other two parties. Oh, I guess we can start; Ms. Martel is here. This

is the last presentation of the day. We thank you for coming earlier so we can go back to our offices. From the Ontario Community Support Association, it's Tony Pierro and Kaarina Luoma. You have 15 minutes. You may wish to start your presentation.

Mr. Tony Pierro: First of all, let me thank the members for allowing me to be here. I know there was a bit of an issue in terms of making time, so I really appreciate it. I also know that we're the only things that are between you and probably a well-deserved dinner, so we're going to be very quick. We'll go through the front part of it very quickly and focus in on the recommendations.

Getting things rolling, on page 1, in terms of who we are, the Ontario Community Support Association represents 360 not-for-profit community support services. We have about 25,000 staff in the sector and roughly 100,000 volunteers, which I'll get into in the next little while because that's one of the key issues with the LHIN legislation that we want to protect. These volunteers deliver roughly seven million hours of services on behalf of your parents, your aunts, uncles and grandparents—a very valuable resource.

The Ontario Community Support Association members receive approximately 1% of the Ontario health budget. We're the front end of the system. What we do is actually avoid people going into what I consider to be the high-end, the high-expense portion of the health system.

On page 3: What we do are the kinds of things that you hear a lot about in your own community: Meals on Wheels, transportation for the elderly to medical appointments, attendant care, adult programs, security checks, friendly visiting, caregiver support—all these kinds of things that allow an individual to stay within their own home and not have to move into institutional care.

On page 4: The OCSA and its members are actually quite happy about the LHIN legislation. We really like the restructuring that is occurring in the health system. We have some common goals in terms of equitable access based on client-patient need, measurable results-driven outcomes. We're really moving as a sector to start to measure what we do, how we do it and what the benefits are to the system as a whole. A number of reports have been written, which I'll actually chat about in about two seconds.

OCSA members are looking forward to working with the health care partners. It's almost like the assembly line of the health care system, making sure that everything is working well, that we invest the right resources in the right areas to get the best outcomes. Again, we really are encouraged by the direction that everything's going.

We also support the changing culture that's required to actually make the health care system more efficient. In terms of the overarching requirements, note page 5. Some of the key principles that LHIN legislation has to embrace are the Canada Health Act, Ontario's Commitment to the Future of Medicare Act, 2004, and consultation with service providers—and this is one of the things that we'll actually get into in a few minutes—which is critical when we're establishing the whole

LHIN organization. Every partner in the health system has to be at the table and represented at the table.

On page 6: One of the key things that we're emphasizing is that consistent criteria as to what is community engagement should be clarified. OCSA looks for a real broad-based, inclusive engagement process, with a strong voice from the local communities. That's really the basis for the LHINs being created: to move them to the local communities, get community involvement and engagement.

The system planning across the whole health care system also has to ensure that human capacity and skills to deliver the care are there when needed.

The last point is that information technology needs to be supported so that we can actually input into the system as a whole.

As I was mentioning before, the not-for-profit agencies have approximately 100,000 volunteers. This is one of the key areas that the legislation has to support. If we lose this resource—they provide roughly about \$100 million worth of resources to the system. This is again everything from Meals on Wheels to attendant care to taking individuals to health appointments. The health care system cannot afford to lose this very valuable and critical resource.

On page 8: When we talk about integration, that's something that our members and our association strongly believe in. We feel that every health care provider needs to have that obligation to coordinate the needs of individuals through the system.

So system navigation—it's actually mentioned in the legislation—isn't a job responsibility of one organization; it's the responsibility of all the health care providers in terms of supporting individuals through the system. If a client contacts an organization, they need to be navigated through the system by that organization.

On page 9: We believe every door is the right door. I'm going to skip that page to get into some of the recommendations.

In terms of efficient management at the local level, which is one of the premises of the LHIN legislation, we really need a strong home and community care system to maintain people in their community. A number of reports have been written. In fact, I think it's time to stop writing reports and actually implement the recommendations from these reports that basically say keeping people in their own home is the most efficient way of doing things from a dollar perspective and also provides the best health outcomes. People want to stay in their own homes. They can stay in their own homes and they want to be there. It's just a matter of having the dollars to do that.

Again, numerous studies indicate that countries with the best health outcomes and lowest expenditures of GDP have strong primary health care systems. That's something that we really encourage the whole process to create.

On page 11: From an investment perspective this gives you an idea of what it costs an individual to be accommodated, whether it's in a hospital, long-term care

or in the community side of things. There's a real good investment to keep people in their own homes.

In terms of the recommendations, starting on page 12: In the legislation it talks about creating advisory committees. We feel very strongly that the advisory committees must be inclusive. There must be broad-based representation from all parties in the health care system, all the partners who actually deliver the health care, and not, as the legislation currently says, advisory committees related to regulated professions. Our sector does not have as many regulated professionals, but we feel that we have to be part of that advisory committee that is advising the local LHIN. OCSA strongly recommends that the community support sector have equal representation on these health advisory committees that are advising the local LHINs. Don't just keep it to the health professionals.

Accountability agreements, on page 13: The essence of LHINs is local responsiveness based on province-wide strategic goals. To achieve this, I think what the OCSA would like to recommend on behalf of its members and the thousands of seniors and persons with disabilities whom we actually serve, is that the LHIN legislation actually speak clearly to the development of outcome indicators for all of the sector. Right now, it's very heavily based on institutional care, but on the community support side of it we really need to ensure that there are health indicators that measure the whole health system and not just certain components of it.

We recommend that the definitions of "efficient" and "effective" must be clearly defined in the legislation or in the regulations to ensure that quality outcomes are defined, that it actually creates innovation and flexibility in service and program delivery. We need to ensure that we're not only doing things right, but we're also going the right things in the health care system.

For the next two recommendations I'm going to pass it on to my associate Kaarina Luoma, who's going to be speaking to actual on-the-ground experience.

1630

Ms. Kaarina Luoma: Hi. My remarks address the recommendations on pages 15 and 16 of the OCSA response before you, specifically: (1) that the local health care services must continue to preserve local community connections, community-based governance and consumer choice, and avoidance of service disruption to clients; and (2) that all health care providers have a role to play in assisting each client/patient find their way through the integrated system.

In respect of the LHINs' efforts to engage communities, our common goals include people-centred, community-focused care that responds to local population health needs; and shared accountability between providers, government, community and its citizens.

I want to illustrate for you how the residents of our city, Toronto, whether as health care providers or as volunteers, contribute to the work of only one agency, and that's my agency, in the downtown east core. Mid-Toronto provides programs and services that bring care

home to seniors and adults with disabilities or illnesses. We serve the community of downtown—St. James Town, Moss Park, and Regent Park—high-need areas with approximately 20% of the city's population but 40% of those living in poverty. We help approximately 1,000 citizens annually through such programs as Meals on Wheels, community transportation to medical appointments or treatment and adult day programs such as Alzheimer care.

I think the story of Mrs. S. is the best way to capture for you what on-the-ground experience is with an agency like ours. Mrs. S. is a 57-year-old who has been on our Meals on Wheels program for over five years. She has received a hot, nutritious meal every day. She has severe arthritis and a history of depression. She's alone in the world with no family or friends nearby, so her only support was the human touch, the hand out that our agency was able to provide.

She was not home one day for her noontime delivery, so the volunteers immediately alerted staff, which is our protocol. The staff tried desperately to reach her. They couldn't. She has no emergency contact other than the superintendent. When the superintendent was finally contacted, he indicated that she had been behaving quite strangely for about two weeks at that point. She hadn't been staying in her apartment at nights. She had been urinating in the streets, hallucinating, acting paranoid and starting to threaten some of the other residents. We were able to contact mental health professionals, whom we consulted with, and they helped us present her case before a judge. Then the police were able to pick her up and get her the treatment she needed. She was in hospital for approximately two months, but then she was returned home and went back to receiving her meals once her mental health condition was stabilized.

It illustrated for me, as one of the people who work in this sector, how vulnerable we all are to quirks of fate and what can happen, and how that community agency is on the ground, seeing the meals go out, bringing your parents to a seniors' day program, or sometimes even your children, because unfortunately that's the only thing that's available out there at this point. Seniors and adults face a multitude of burdens: Alzheimer's disease, cancer, heart disease, depression, HIV/AIDS. It's too common to listen to her story, so I won't go on about it, but it just shows you that it also resurrects the housing issue in this city and the lack of affordable homes for people to reside in.

It is the support of over 1,000 volunteers, who contribute more than 16 staffing positions to my agency alone, and the due diligence that that support carries through to our funding partnerships: the Ministry of Health, the United Way, the city of Toronto etc.

During SARS and the August blackout, we never closed our doors. St. Mike's was on a generator; they were able to provide our hot meal entrees. Staff and volu-

nteers carried meals up 26 flights of stairs in the pitch black. I remember delivering that day as well—actually it was three days, I think. A little woman was asking, "Kaarina, do you think I could go to the hairdresser today?" I said, "No. Today is not a good day. The city is little bit shut down today." It's that human touch that people need, who have no other means of getting out to social kinds of situations.

This is how Mid-Toronto, which is just one agency in this whole network across this province, delivers services to clients and improves access to services within our diverse communities. It's through the strength of our volunteers, accountability to those in need in our community and integrating our resources and expertise with other providers when needed. We do this constantly.

We have a 40-year history of collaborative efforts. Currently, one of the bigger projects before us is the Senior Pride Network, which is quite a collection of mainstream agencies and age-specific providers teaching each other and learning from each how to reach out to these populations so that nobody stays isolated in their own home because they're too threatened to access what care might be out there. Again, we try to bridge those kinds of realities.

To strengthen and grow integration effectively, we fully support the OCSA recommendation of establishing a requirement for LHINs to incorporate an analysis of the impact of any integration plan on the community, volunteerism, people being served and the health service provider. By building on our strengths, we will move Ontario to a health system that can afford every Ontarian the care they deserve.

In closing—you've probably heard this before if you heard the city presentation—I would like you to picture Toronto supported by an invisible fabric that is really, when you look closely at it, an incredible network of agencies that support each other. Somebody might have more capacity there; somebody, less. But some are crippled right now. They are really at the point of not going on, and that's something that I hope this legislation is going to be able to address.

It is my hope that the LHIN legislation will preserve the ability of local not-for-profit agencies to continue to reach out to those at risk and vulnerable. People need to be supported at all points, starting with their first point of contact with the health care system, and the community support sector is often the first point of contact for clients.

Thank you. I talk too fast.

The Chair: Thank you to both of you for your presentation. There is no time for questions, but if somebody wants to ask a question, they can certainly do that; otherwise, thank you.

We will resume deputations tomorrow at 9 o'clock at the same place. Good night.

The committee adjourned at 1638.

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Local Health System
Integration Act, 2006

Comité permanent de la politique sociale

Loi de 2006 sur l'intégration
du système de santé local

Chair: Mario G. Racco
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 7 February 2006

Mardi 7 février 2006

*The committee met at 0905 in committee room 151.*LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

ONTARIO FEDERATION OF LABOUR

The Chair (Mr. Mario G. Racco): Good morning. I think we should start since all of us are present. This is our sixth day. The first presentation this morning is from the Ontario Federation of Labour, Terry Downey. Good morning. Please start whenever you're ready. There are 15 minutes allocated for your presentation. If there is any time left, we'll be happy to ask some questions.

Ms. Terry Downey: Great. Thank you.

Good morning. My name is Terry Downey. I am the executive vice-president of the Ontario Federation of Labour. The OFL welcomes this opportunity to appear before the standing committee on social policy to discuss the proposed legislation, Bill 36, the Local Health System Integration Act, 2006. The OFL constitutes the largest provincial federation of labour in Canada. Our 700,000 members are drawn from over 40 unions. Our members work in all economic sectors and live in communities across Ontario, from Kenora to Cornwall, from Moosonee to Windsor.

We believe that committee hearings are a vital part of our parliamentary democracy which allow interested individuals and organizations the opportunity to share their perspectives on proposed legislation with their elected representatives. Given the importance of this proposed legislation, there should have been extensive public hearings in communities across Ontario. There have not been, and that is a sad reflection on the government that won an election on the slogan "Choose change."

This proposed legislation will have a profound negative impact on the quality of health care available to and delivered by Ontarians across our province. We are not alone in this assessment. Like members of the committee, we have attended all of the committee hearings

across Ontario: in Toronto, London, Ottawa and Thunder Bay. Like you, we have heard the concerns raised by Ontarians. It is incumbent on the committee members, especially members of the government, to use their influence to alter this proposed legislation to better address the concerns of Ontarians. We will briefly discuss a number of concerns regarding Bill 36.

Our vision for health care draws on the experiences of dedicated health care workers who provide needed services and who are profoundly troubled by the misdirection of public policy and the failures of the institutions which employ them; and workers and their families who in the past used, or continue to use, the services of Ontario's health care system.

Recent examples of our advocacy in health care include the discussion and endorsement by delegates to our recent convention last November of a comprehensive paper called Rebuilding Health Care. Another example is our campaign on understaffing. In May and June of last year, the OFL organized meetings in 15 communities across Ontario with workers from all sectors of health care. They came to the mutual conclusion that all sectors and workplaces have been hard hit by understaffing and that the problems associated with understaffing are systemic and serious. The report, *Understaffed and Under Pressure: A Reality Check* by Ontario Health Care Workers, was released in October 2005, and a copy was sent to every MPP. The report concluded:

"There is no health care without people. The Ontario government must immediately and significantly increase staffing members in all sectors.

"For starters, the provincial government must:

"Declare an immediate moratorium on layoffs in hospitals.

"Establish a required minimum standard of 3.5 hours per day of nursing and personal care for residents in nursing homes and homes for the aged.

"Establish required minimum standards for staffing with appropriate complement of full-time workers in all health care sectors."

The work of health care economist Armine Yalnizyan illustrates that there are financial resources available to the government to address this issue. The Ontario labour movement has and will continue to lobby for positive and immediate action to address the issues and impact of understaffing, which we consider a fundamental issue in health care. This proposed legislation will do nothing to address this important issue.

Bill 36 is an Orwellian exercise, the latest instalment of this government's vision of health care in Ontario. The preamble of the bill contains noble words that do not reflect the intent of this proposed legislation, which gives little power to health care providers, the people they serve or local communities to make decisions concerning health care. Instead, Bill 36 transfers control of such decisions to the Minister of Health and Long-Term Care and cabinet through their creation of the local health integration networks, the LHINs.

The LHINs are presented as a made-in-Ontario solution for challenges facing our health care system. From our perspective, the government has pre-determined that LHINs are the "cure" which will be imposed on patients in Ontario. This cure is based more on faith and ideology, we believe, than on the reality of the needs of Ontarians.

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We view Bill 36 against the backdrop of what the state of health care is in our province. An important part of this cure is concern with costs.

We find it odd that given the goals found in the preamble already cited, whole sections of our health care system are not included under this proposed legislation. Physicians, the gatekeepers of the system, are left out. Hospitals are included but ambulance services are not, a fate they share with public health. Hospital labs are in but not private ones. Psychiatric hospitals run directly by the ministry are out but divested facilities are in. Independent health facilities are out, as are provincial drug programs. Long-term-care facilities are in but homes for special care are out. There is a provision in the proposed legislation to move services around, but this present configuration suggests to us that there will be a disconnect between services.

The Orwellian nature of Bill 36 is most evident in the issue of governance. The LHINs are local in name only. This is an exercise in the centralization of power and decision-making. The board, chairs and vice-chairs of the 14 LHINs are chosen by cabinet and serve at their pleasure. The cabinet may create, amalgamate, dissolve or divide the LHINs. LHINs are defined as an "agent of the crown." LHINs enter into accountability agreements with the ministry on such matters as performance goals, measures and plans for spending. Each LHIN must develop integrated health service plans within the time and form specified by the minister which are consistent with provincial strategic plans. It is obvious, though, that the LHINs are creations and creatures of the provincial government.

The LHIN structures will be politically beneficial to the provincial government. The most obvious benefit is as a vehicle for the implementation of government policy. Given the nature of appointment to the LHINs, they will be unaccountable to the local community and unlikely to oppose provincial government initiatives. If community opposition to these initiatives develops, the provincial government will insulate itself from criticism by simply pointing out that the LHINs, not the provincial government, made the decision in question. The same

tactic will likely also be used against opposition MPPs who may wish to question members of the government.

Through Bill 36, this government has turned its back on a long tradition in Ontario of locally elected representation who carry out their responsibilities while still being responsible to their local community. It appears this government believes that "a community's health needs and priorities are best" determined without the local democratic involvement of "community, health care providers and the people they serve."

The proposed legislation makes a mockery of the already quoted preamble. Fourteen LHINs cover the province of Ontario. Five of them serve populations larger than five Canadian provinces. As a provincial organization, we have an appreciation of the size of Ontario and the distance between communities, an appreciation which seems to be lacking among those who have created the LHINs. Some examples of the distance and travel between communities in the same LHIN are: Scarborough to Haliburton, 203 kilometres, 2.5 hours; Cornwall to Pembroke, 248 kilometres, three hours; Parry Sound to Timmins, 468 kilometres, six hours; and Kenora to Thunder Bay, 491 kilometres, 6.5 hours. I think this illustrates the point yet again that there is little local in the LHINs.

The current LHINs boundaries do not make sense to Ontarians. For example, Ontarians who live in the city of Toronto find themselves in a number of different LHINs. Common sense suggests that this will be a disaster for everyone involved: the users of the service, the workers who provide the service and the city of Toronto itself.

Communities with little historical connection are lumped together in the same LHIN. Given the size and diversity of the areas covered by the LHINs, there will be significant conflicts over resource allocation. The most likely scenario will be that smaller communities will see their existing services integrated into the larger centres in the LHINs. The loss of these services in the community will force Ontarians to travel to where the services are available. It will be destructive for their families and likely result in increased costs for travel and lodging. Communities will lose their economic and employment spinoffs of having these services in the communities. Communities without a range of services will become less attractive as destinations for economic development.

The francophone community in Ottawa made this committee aware of the needs of their community for French-language health care services. The Canadian Hearing Society shared with the committee the need of deaf and hard-of-hearing Ontarians. These are two examples of the needs of Ontarians of particular communities that could be overlooked in this current LHINs model.

Bill 36 gives the government and LHINs a range of tools which can be used to restructure existing health care organizations. The LHINs are given the responsibility to provide funding to the health service providers for the provision of services.

I'm just going to kind of wrap up because I know I'm getting along, but there are some sections of concern that you'll find in our report about sections 28 and 33. For the labour movement, these sections of Bill 36, taken together, are clear indications of the thinking of this government: It's the appeal of competitive bidding, a bias for profit over non-profit models and for privatization of services. This approach, we believe, will be disruptive for the lives of our members who provide the needed services and Ontarians who need these services.

The OFL has worked closely with our affiliates on the issue of understaffing in health care. There's an obvious need for a human resources strategy for our health care system, but this seems to be overlooked in the proposed legislation. The recommendations from our OFL report should be part of such a strategy. The issues of retention and recruitment of qualified personnel are critical. Rumours and talk of amalgamation and transfer of services within the LHINs boundaries will make it more difficult to find people to move to where their expertise is needed.

A provincial strategic plan should be the starting point of building and sustaining the kind of health care system in terms of what we want in our province. The active involvement of the labour movement, especially our affiliates in health care, would be most helpful to this process. In Bill 36, section 14 mentions a provincial strategic plan, and section 15 notes that each LHIN will develop their own strategic plan. The government appears to want to rush the LHINs into service prior to the development of a provincial plan. Perhaps a strategy is to enact change first and then develop a plan. However, it makes little sense for LHINs to spend time on resources to develop a plan which must be consistent with a provincial plan that has not yet been developed.

In conclusion, we share the concerns raised by our affiliates. The all too brief public hearings undertaken by this committee have given you a clear indication that Ontarians are very concerned about the LHINs and the impact on our health care system.

To the government we would say, withdraw Bill 36 and commit yourself to an inclusive process to involve Ontarians in the development of a provincial strategic plan for our health care system. Thank you.

The Chair: Thank you. We have this lovely book. All of us have one. All the information is here. We thank you for your presentation.

ONTARIO FEDERATION OF
COMMUNITY MENTAL HEALTH
AND ADDICTION PROGRAMS
CANADIAN MENTAL HEALTH
ASSOCIATION, ONTARIO
CENTRE FOR ADDICTION
AND MENTAL HEALTH

The Chair: The next presentation is from the Centre for Addiction and Mental Health, the Canadian Mental Health Association of Ontario, and the Ontario Feder-

ation of Community Mental Health and Addiction Programs. There are three of you: Karen McGrath, Gail Czukar and David Kelly. Good morning. You can start any time you're ready, please.

Mr. David Kelly: I just wanted to indicate, just to clear up a little bit of our side that it is Karen McGrath, CEO of the Canadian Mental Health Association; I'm David Kelly, executive director of the Ontario Federation of Community Mental Health and Addiction Programs; and Gail Czukar is executive vice-president, policy education development for the Centre for Addiction and Mental Health. You may ask, why are we here together to present to you? In reality, we came together as a sector about two years ago, realizing that people with mental illness and addictions were being sidelined in the health care system. We came together, realizing that we had to put some of our differences aside and work and clearly be focused on clients and how they work through the system. So we're very proud of what we've been doing, and we have been at the forefront of the transformation agenda since that time period.

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We also want to take this opportunity to thank all members of the Legislature for the support that they have brought to mental health and addiction services. We know it impacts all of our families, and without you and your support, we would not be able to go forward and really address key social issues.

We're not going to go right through our presentation. We know you have copies of that. We'd like to have some interaction with you, if possible, but we want to just highlight some of our major concerns.

The first one that we're going to go to is about getting "health" to include mental health. So when we go into the preamble of the legislation, we would really recommend that the preamble should define "health" as inclusive of both physical and mental well-being. I just would like to highlight that the government saw the wisdom of this action in the Commitment to the Future of Medicare Act, where we, as three organizations, came together to make that.

Secondly, we want to just talk about and touch on local communities and that local communities know best. In the mental health and addictions sector, consumers, family members and volunteer boards all play key parts in supporting our system. Their involvement is crucial to the success of moving an acute-care-focused system back down to a community level. All of those groups, people and participants strengthen the system. They know they are on the front lines. They are the first ones to see issues, and they are really key to making a success.

I'm going to turn it over to Karen McGrath now to highlight some other issues.

Ms. Karen McGrath: I'm going to ensure that everybody is awake this morning by pointing out a typo, first of all, in our presentation. On page 5 of the presentation, under the title which reads "Suggested Amendment," we recommend adding a clause in section 15, not 14. The first eight words should be removed and it should start

by: "That health services include both physical as well as mental health and addictions services." So I just want to make sure.

While we said we weren't going to read, continuing with the key messages, we also want to make sure it's understood that this partnership has been very supportive of the transformation agenda of this government. So our key messages are in the spirit of bringing forth issues that we believe should be addressed by revision to the legislation.

The first one is that we would urge the committee to recommend a broad definition of "health service provider" to facilitate integration and comprehensiveness. It's not clear that they're excluded in the legislation, but it's also not clear that they are included.

I want to talk a bit about planning and the references to planning in the legislation. First of all, we would strongly urge the government to coordinate both the provincial and local strategic plans. This is essential for this initiative to be successful. You need to ensure that consumers, families and local providers have meaningful input into the plans, and then ensure that LHINs have regard to that input. So there have to be mechanisms that keep the LHINs accountable to the communities that they serve. We also would strongly urge government to require plans to address mental health and addictions specifically, that those elements of the plan be identified in each of the local plans.

I'll now pass it over to Gail.

Ms. Gail Czukar: I'm going to address the integration sections of the bill.

We feel that the bill overemphasizes strategies that lead to mergers and amalgamations and consolidations at the expense of other kinds of integration initiatives that providers, families and consumers might take on on their own.

That's a function, I think, of section 27 and the definition of "integration." So the definition of integration is very broad and really talks about any partnership or any effort on the part of organizations to work together. If organizations want to do that, even two organizations, they have to give notice to the LHIN, and they have to wait 60 days before they can implement anything. I think this has been raised previously by Steve Lurie, who is from the CMHA in Toronto. I would suggest that the bill be amended to exempt the application of that section, or at least the 60-day waiting period, where there's no transfer of a program or a budget so that the people in local communities can continue to take initiative and be active in coordinating and integrating their local system.

The last parts of our brief talk about the sections that others have addressed before you about the power of the minister in section 28 to actually close organizations. We would suggest that that be deleted. That's certainly an exceptional power. As counsel in the Ministry of Health for many years, I worked on a lot of legislation. This is an exceptional power of the minister, to actually close the operation of an organization altogether. It's one thing to order programs to merge or cease operations, but to close an organization is quite exceptional.

The other issue would be equalizing the field between for-profit and not-for-profit providers. Again, a lot has been said about this. There's been talk about discrimination against not-for-profit providers. I've looked closely at those sections of the bill. I can see that it's positive in the sense that it means that not-for-profit services can't be transferred to for-profit providers, but I don't understand why the services of for-profit providers that are supported by public funds can't become the subject of integration orders, which is the effect of that section.

Those are our submissions. We'd like to have an opportunity for questions.

The Chair: There is plenty of time. We have about four and a half minutes total. I'll start with Mr. Arnott.

Mr. Ted Arnott (Waterloo-Wellington): Thank you for your presentation. We were all awake when you came in, after several days of this. I thought your presentation was excellent. I want to focus on your suggestion on page 8 about section 28, asking that the section which allows the minister to order an organization to close be deleted. You had indicated that you'd worked a lot of health legislation in the past. Why do you think this was included in Bill 36?

Ms. Czukar: It would be hard to conjecture what the intent of the drafters was. It's not a LHIN power, it's a ministerial power, so it would obviously be exercised judiciously, I'm sure. I suspect it's because if you order the integration of services of two organizations, what is that resulting organization going to do? But our law allows for corporations to exist under the Corporations Act or the Business Corporations Act. That's a fundamental legal tenet.

Mr. Kelly: I would just add to that that a dollar invested in the not-for-profit community sector results in approximately \$1.43 in services. Oftentimes, the government is not the sole funder or support for those organizations. There are whole components that are run off that not-for-profit because of their connections in the community, how they operate and the support from their local community in building that organization.

Mr. Arnott: And that needs to be respected.

The Chair: Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you to the three of you. The last time I did see you together was for Bill 8.

Can I follow the section a little further with respect to the integration of only for-profits and nothing with respect to not-for-profits? The suggestion has been that we either include for-profit providers under that section or delete the section altogether. What would be your preference in that regard? I'm not trying to test you. Do you have a preference?

Ms. Czukar: Sorry, to delete which section altogether? Section 28 or 27?

Ms. Martel: Section 28. You said that the power to close be deleted. I just want to be clear that that would be the preference versus having orders apply to the for-profit sector as well.

Ms. Czukar: This is obviously off the top, but I would say we would prefer to see it deleted. I think ordering mergers of for-profit and not-for-profit organizations does run into a lot of problems and would raise the concern, which I think is not here at the moment, of having services transferred from the not-for-profit to the for-profit sector.

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The Chair: Thank you. Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Thank you very much for being here. I wanted to ask you whether, in your conversation about section 27, the 60-day provision—obviously your organizations have seen the benefits of working together, not just to come and talk to us, but on service delivery and communication around clients. Are you saying that you see, possibly, a barrier in this legislation to some of the informal co-operation that can happen spontaneously in the community and that we should be careful not to hobble that?

Ms. McGrath: Create obstacles? Yes, absolutely.

Mr. Kelly: Absolutely. There's planning, coordination, improvement in access going on right across the province in mental health and addiction fields right now. We have groups that are literally hitting the ground running in trying to work through some of the support dollars that have come in and make the system function better. Our concern was around that saying, "You have to get approval for 60 days," would stop some of that. If there's no transfer on the funding and it's not having a negative impact upon clients or outcomes within the service field, then these groups should be encouraged to do that.

Ms. Wynne: I am absolutely sure it was not the minister's intention to put up barriers to that kind of co-operation. But you're saying that your legal advice is that there would be a restriction on that kind of coordination or co-operation if this legislation passes the way it is?

Ms. Czukar: I think the other option would be for the LHIN—I mean, the intention of this, obviously, is for the LHIN to manage the system, so that where there's activity that's going to have organizations working together, they know what that is. Over time that may be possible; I don't think initially the LHINs are going to be in a position to so actively manage the system.

The other possibility would be for either the minister or the LHIN to have discretion to exempt organizations from that so that in the beginning, at least, they can say to a group—say they wanted to say to all the mental health and addiction organizations in their area, "We want you to work together on coordinated access to the system. We'll give you six months or a year to come up with a plan", organizations could go ahead and initiate projects without waiting for approval from the LHIN. You don't want to paralyze the system as we go through this transition.

Ms. Wynne: I completely agree with you and that's certainly something that I will take back, because I would hate to see that kind of barrier. Since I'm sure it wasn't

our intention, we'll try to figure that out. Thank you very much.

The Chair: Thank you for your presentations.

CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

The Chair: The next presentation is from the Canadian Memorial Chiropractic College, Dr. Jean Moss. Good morning, doctor.

Dr. Jean Moss: Good morning, everybody. I'm Dr. Jean Moss, president of the Canadian Memorial Chiropractic College, commonly known as CMCC. It is a private, not-for-profit, degree-granting academic institution that has been providing post-secondary professional education to the majority of Canadian chiropractors since 1945. CMCC is a leader in chiropractic health research and provides excellence in clinical care in multi-disciplinary environments. We have a number of very interesting relationships with other organizations which I think this legislation does not cover. We're pleased to comment on the proposed legislation, Bill 36.

CMCC's commitment to health care renewal has been demonstrated by our provision of chiropractic care in multi-disciplinary environments to patients in the community in which they live and work.

The proposed LHINs legislation does not contain provisions that address health care renewal through integrated primary health care delivery and inter-professional care. We believe that, through LHINs, there should be improvement in access to a variety of health care services, improvement in quality and continuity of care, increased cost-effectiveness, and increased patient and provider satisfaction, while the effective use of our health care resources is ensured.

CMCC has demonstrated experience working in an integrated manner. As an academic institution, we provide clinical training through community-based chiropractic clinics, including clinics located inside community health centres, such as Anishnawbe Health Toronto and South Riverdale Community Health Centre. We provide clinical services in hospitals such as St. John's Rehabilitation Hospital and St. Michael's Hospital family and community health department. We provide services to other in-need populations such as at the Muki Baum Centre, a centre for adults and children who are behaviourally, mentally and physically challenged, and for the Donwood Institute, which is associated with the Centre for Addiction and Mental Health. We also operate two community-based clinics, one at our campus on Leslie Street at Steeles in north Toronto and the other at the Sherbourne Health Centre, a health centre dedicated to providing accessible care in an environment that supports traditional and complementary therapies to service the needs of the community, including the HIV/AIDS patient group. Our clinics are located within the Central Health Integration Network and the Toronto Central Health Integration Network. Sorry, that's a bit of a mouthful.

Our clinics operate under principles similar to those of the LHINs. We provide patient care to improve population health by implementing wellness and disease-prevention strategies; evidence-based practice to achieve positive health outcomes; integrated health care services at the community level; continuum of care through health promotion and wellness; education as the cornerstone for inter-professional and interdisciplinary care; access to primary health care for certain population groups to whom it is traditionally limited; and services that are culturally diverse for the aboriginal population and disadvantaged groups.

It is with this background and experience that we offer the following comments on the proposed legislation:

The legislation does not provide for input by Ontarians into the development of an integrated health service plan, or IHSP;

The legislation excludes some health services, such as chiropractic, from the definition of health service provider. This definition appears to be inconsistent with definitions in existing legislation and makes it difficult to assess how coordination of services across a local health integration network could be possible;

The composition and mandate of the health professional advisory committee is unclear;

The legislation does not provide a framework to identify how funding will be provided to meet the local community's needs;

The legislation does not provide meaningful and accountable oversight of integration and funding decisions to ensure that patients' needs are met in their own communities. Several of the LHINs will be very large in terms of both population and geographically, and I think we've already heard comments to do with that. It calls into question their ability to address health service needs within their diverse communities;

The legislation is unclear on the extent of public consultation that must be entertained by each LHIN in determining community needs and priorities;

It is also unclear on the role for community engagement in the development of IHSPs and in setting priorities on how the community engagement shall occur;

It is unclear on how community health centres will be integrated into LHIN priorities, including their funding; and

The legislation is silent on the importance of patient choice in access to inter-professional care and on the role of academic health science centres.

Based on these shortcomings in the legislation, we offer the following recommendations:

Regulations should outline how the general public and health professions will have input into the development of an integrated health service plan for Ontarians. All providers and patients of existing community-based programs should be consulted and their feedback should be included in health care renewal decisions. An amendment to the legislation should include a description of the specific elements or components of the IHSP—scope,

timeframes, resources, expected outcomes and implications for providers.

The legislation should ensure that appropriate and complete input is provided into health transformation decisions within the LHINs through community engagement. The community with which LHINs must consult regarding the development of IHSPs should include citizens, stakeholders, educators and health care providers. The consultative process will be critical in determining what programs and services will be offered within a community and will ultimately have significant impact on health care providers.

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The definition of health service provider should include all health care providers and, at a minimum, those regulated under statute in the province of Ontario who contribute to maintaining and promoting the health of Ontarians. The exclusion of chiropractors as health service providers is an oversight in the legislation. Chiropractors are primary-contact health care professionals, regulated by legislation in every Canadian province. They are one of the most frequently accessed non-physician provider groups in Canada, with about 12% of the Ontario population and about 35% of those suffering from musculoskeletal disorders seeing a chiropractor.

Funding allocations should be made to health professions, services and programs which contribute to the IHSP in the most effective manner. For example, government and health care reports reveal that chiropractic health care can be cost-effective in the treatment of musculoskeletal conditions. Delivery of health care should be realigned to ensure that musculoskeletal conditions are managed by those health professionals trained to provide such care in the most cost-effective manner. Lack of funding for these services particularly impacts those in most need, typically the financially challenged. Chiropractic could offer relief to the health care system by appropriate triaging of care. To date, health care transformation initiatives have failed to take into consideration the roles that chiropractors can play as members of the health care team.

CMCC has successfully demonstrated its ability to collaborate with other health professionals in managing patient care in a number of its community-based clinics, including some in hospital settings. Preliminary results on a demonstration project where chiropractors are on staff at St. Michael's Hospital have shown a reduction in wait times for physiotherapist service at the hospital. This project within the hospital has been a huge success. This is a result of the development and implementation of a collaborative patient care model to improve continuity and coordination of interdisciplinary care in a hospital-based primary care unit.

The legislation should be clear on how the services currently offered through community health centres will be maintained within the framework of the LHIN. CMCC currently operates chiropractic clinics within two CHCs, and I've already mentioned those. These communities are mainly underserved and economically challenged, with

the result that CMCC's ability to charge for its patient services is restricted and thus we absorb the cost for these health care services. Our clinics provide universal access to chiropractic health care services for patients, when and where they need it. Amendments to the legislation should include guiding principles for funding that will ensure funding of providers and programs that build towards inter-professional care, equitable access to the continuum of care, and effective and efficient use of health care resources.

The legislation should be amended to include criteria for issuing decisions that take into account patient choice of access to health care providers; quality and access to health services such as rehabilitation, teaching and research; facilitating inter-professional care, and availability of health human resources.

Integration is key for health care system renewal. It is important that integration decisions are based on best practices, evidence and research and that all LHINs are working from the same principles or criteria. The professional advisory committees within LHINs will have a significant role in contributing to the process of integrating decision-making with the development of the IHSP plan. As such, the composition of such committees should include health providers, health science academic groups, researchers and educators.

Integrated primary health care delivery and inter-professional care will improve access to health care services, improve quality and continuity of care, increase cost effectiveness and increase patient and provider satisfaction while ensuring the effective use of our health care resources. Once the gaps in this legislation are addressed, we look forward to working with the two local health care integrated networks that impact directly on our community-based clinics, and sharing the successes and positive outcomes we have experienced through working collaboratively with other health care providers.

Thank you for allowing me this time.

The Chair: Thank you, Doctor. We have two minutes total. I will ask Madame Martel; 30 seconds, please.

Ms. Martel: Thank you for your presentation here today. I am looking at the recommendation, or point number 3, that says, "The exclusion of chiropractors ... is an oversight in the legislation." I would assume that you want chiropractors included in the legislation.

Dr. Moss: Well, the legislation doesn't really include any of the health professionals unless they're working within the organization within the LHINs. I can see lots of problems coming. It's very unclear, for example, with the CHCs. Some physicians are going to be inside the act and some of them are going to be outside of it. Chiropractors don't appear anywhere and yet we're offering services within those environments and would like to see other community health centres start to offer those services. What we find when we offer those services in those types of environments is that economics is a huge barrier to patients accessing us, and that the patients the chiropractors see in those environments are far more complex cases, with a lot more co-morbidities, and the

success rate therefore is that much higher. It gets them back into work.

Ms. Wynne: Thank you very much for being here. I look at section 16(2), where it states, "Each local health integration network shall establish a health professionals advisory committee consisting of the persons," blah, blah, blah, "of those regulated health professions." So the regulated health professions are included in those committees. You see chiropractors as part of that group, presumably.

Dr. Moss: Absolutely.

Ms. Wynne: So you're reflected there as much as any other regulated health professional. You're satisfied with the composition of the advisory committee?

Dr. Moss: Yes, we're satisfied with the composition; we just want to make sure that chiropractors are actually on those advisory committees.

Ms. Wynne: I guess I see the regulated health professionals, including chiropractors, and so that would make sense.

The other piece is the community engagement, and you've suggested that regulations should outline community engagement on the provincial plan. For sure, regulations will outline community engagement on the local plans. I guess if you have specific ideas about what that community engagement should look like and what should be in the regulations, at some point in the future you might want to let us see that.

Dr. Moss: Absolutely.

Ms. Wynne: Thank you.

Mrs. Elizabeth Witmer (Kitchener-Waterloo):

Thank you very much, Dr. Moss. Just about the whole issue of chiropractic: Since the Liberal government delisted chiropractic services, what impact do you think it's had on the health of Ontarians? I think you're speaking here about the fact that those who obviously don't have the financial wherewithal are not able to have access to the services.

Dr. Moss: Absolutely. I think there has been a significant decrease in the patients seeking chiropractic services. A study was done by Deloitte & Touche before the decision was made showing that those patients would be seeking other health care services and actually increasing costs in other areas. I can tell you specifically for our institution what the delisting has meant: It has meant that the institution is providing health care services in many cases for free, so indirectly our students with no OHIP coverage are actually bearing the cost of those services.

The Chair: Thank you very much for your presentation.

INDEPENDENCE CENTRE AND NETWORK

The Chair: The next presentation is from Sudbury. It's a videoconference. We have on the line Valerie Scarfone and Tyler Campbell, and on the screen too.

Good morning. Please proceed with your presentation. You have 15 minutes total time.

Mr. Tyler Campbell: Thank you very much, Mr. Chair. I would like to start by thanking the committee for using videoconferencing this morning to allow smaller organizations like ours to present to you without having to travel to Toronto.

ICAN, the Independence Centre and Network, is a non-profit organization incorporated in Sudbury in 1979. ICAN was founded in response to a need for support for individuals with physical disabilities in order to avoid institutionalization. As a result of hard work on the part of parents and concerned citizens, programs and services were created to afford individuals with physical disabilities the opportunity to live an independent lifestyle. Since 1979, the organization has developed life skills training programs, respite services, supportive housing and outreach for adults with physical disabilities. More recently, ICAN has added a life skills program for teens with disabilities and a volunteer-driven peer support program.

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ICAN is governed by a group of volunteer directors, made up of members of our community with diverse backgrounds. All directors on the board are committed to the principles of independent living.

We value full participation in community life, respect for individuals, shared responsibility and partnership, excellence and innovation.

ICAN services are provided with the independent living philosophy, which means we promote consumer choice and control. Services provided are non-medical and individuals supported are not sick but have permanent physical disabilities, which necessitates ongoing support. Services are provided in the person's home, at work or school.

Members of ICAN felt that it was important to provide this committee with feedback on Bill 36 in order to provide the perspective that community support services provide essential, non-medical support in the larger health care system.

ICAN is an active member of three provincial associations: Independent Living Service Providers, the Ontario Community Support Association and the Ontario Non-Profit Housing Association. These provincial associations are a collective voice to effect a positive change in our capacity to provide services and to network through peer support and professional development.

We welcome the opportunity to provide you with insight into each section of the act from our perspective.

Ms. Valerie Scarfone: Section 1: The government is to be commended for the goal of making our system more effective and efficient with the development of the LHINs. The current health care system is difficult to sustain in its present model. Keeping more resources in the non-profit sector would improve accountability and put every dollar into service.

Health improvement for people with a disability means access to reliable daily supports that allow for full

participation in community life. Supports from attendant care facilitate enrolment in post-secondary education and promote working in competitive employment and living independently.

We are in support of the general purpose of the act. Our agency has given priority to the development of partnerships and alliances with other organizations to meet our client needs. We have formal partnership agreements with the Canadian Paraplegic Association, Ontario division, our local branch of the Canadian Mental Health Association, and we have a purchase-of-service agreement with the Manitoulin-Sudbury Community Care Access Centre to ensure the right service, at the right place, at the right time. In Sudbury, we are currently co-located with the local brain injury association, as they rent our facilities at cost. Those are just some examples of our integration efforts.

ICAN also has a strong, well-established working relationship with Sudbury Regional Hospital. The past two individuals accessing our supportive housing services have come from the hospital setting. One individual came from rehab and the other person came from continuing complex care, and she lived there for over six years. These are young citizens who need to live an independent life and make contributions to our communities, and they can do that by living in a supported environment in the community.

We have an informal referral protocol with the hospital that provides individuals coming from there with immediate service in our Independence Training Centre, and we share all necessary professional reports and avoid the duplication of service.

Enshrining principles like this in legislation is critical to system improvements.

The LHIN corporation: The objects of the LHIN corporation need to have increased emphasis on quality. The quality of services provided in our health care system needs to be a priority for the LHINs. Having quality standards and measurement tools for health service providers is key to system improvements, including community standards, not just institutional standards. It will be important for the LHINs to involve the community support sector in the development of these quality standards and for all sectors of the health care system to be partners in the decisions and the development of those standards.

The mention of client-patient consumer choice could not be found in the legislation. Individuals requiring life-long support need to have a choice of provider and options for independent living. Long-term-care homes, for example, are not appropriate options for young people with disabilities. The power of this legislation to order integration even at the expense of the demise of the service provider could very well threaten the quality of service and, at minimum, could have a negative impact on the issue of choice for individuals needing service. Services provided in the community operate under the model of support that promotes wellness of the individual, lifelong supports that allow individuals to be active and contributing members of our community.

The issue of research needs to be addressed. The importance of evidence-based decision-making through appropriate research needs to be highlighted in the legislation. Research needs to be an integral part of system improvement, with an emphasis on best practices. Currently, ICAN in Sudbury is involved in a research project with the Sudbury Regional Hospital and the Manitoulin-Sudbury Community Care Access Centre. The research is on providing community supports to individuals who have had a stroke. Research like this will provide the LHINs with evidence-based documents that will assist in planning functions.

“Community” and “community engagement” need to be defined. Community-based planning needs to include extensive input from providers, consumers and individuals from all walks of life. Community engagement must be accessible to individuals with ranging abilities. Mobility factors must be considered, and the need for interpreters for both individuals with augmentative communication needs and for individuals with hearing or visual support requirements. Community engagement needs to include connections with multiple associations, groups, committees and individuals and their communities, including the most vulnerable, like individuals with physical disabilities. Community engagement needs to include cross-sectoral participation and cross-government ministry participation. The community engagement must take into account different parts of the province and the inherent geographical challenges that presents for northern Ontario.

The health professionals advisory committee: We strongly recommend the addition of unregulated health care professionals; for example, personal support workers and social service workers. The health care system is broader than those professionals identified as regulated health professionals. Expanding membership of the health professionals advisory committee removes existing silos and gives all professionals equal input. In order to be inclusive of community support agencies, quality, trained staff at every level need to be included in the health professionals advisory committee.

Funding: In order to have a stable health care system, multi-year funding is required not only from the Ministry of Health to the LHINs, but from the LHINs to health service providers. Currently, community support agencies are funded on an annual basis, with little or no increases to account for inflation or rising costs. Funding for the community support sector needs to be protected and have the same benefits as other sectors. We need to have multi-year funding commitments from the LHINs. The community support service sector has the capacity and the ability to provide more services in the community. We need the financial resources to make it happen.

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It is encouraging to see the inclusion of a section in the legislation that speaks to crossing LHIN boundaries for services. ICAN commends the government on no restrictions on patient mobility.

Integration: Integration decisions and orders need to be supported by a strong business case, taking into account the impact on the people served, the community, volunteers and the health services providers. The approach to integration must be transparent and fair. There must be due process to object to integration decisions and integration orders. Currently, the legislation allows for 30 days to make an objection to integration orders. This does not provide enough time for service providers to engage their boards of directors and required legal counsel.

In relation to integration orders, many organizations do not receive 100% of their funding from the Ministry of Health and Long-Term Care, and removing a portion of an organization's funding could cause the collapse of service to clients. It is of paramount importance that integration orders be given due consideration and time for extensive input.

Finally, having a stable employment base is important to the provision of quality services. Employees need protection of their work, benefits and pensions in order to keep them working in this sector. Long-term, committed employees are the backbone to organizations like ours. In all integration decisions and orders, maintaining a stable workforce must be a consideration.

Mr. Campbell: In closing, we would like to thank the committee for the opportunity to present to you today. We hope you will find the recommendations useful in your considerations for amendments. Thank you.

The Chair: Thank you very much for your presentation. We don't have time for questioning, but we would love to have a copy of your presentation. If you can send it to the clerk, we will all get a copy.

Can you see us from your studio?

Mr. Campbell: Yes.

The Chair: Terrific, because we can see you very well. We thank you again for your presentation.

That's a nice and cheap way of being able to reach the entire province, eh?

CANES HOME SUPPORT SERVICES

The Chair: The next one is CANES Home Support Services. Velma Jones and Gord Gunning, good morning. You can start any time you are ready, please.

Ms. Velma Jones: Good morning. Thank you for giving us the opportunity to come and speak to your committee this morning. I'm Velma Jones, president and chair of the board of CANES Home Support Services. With me this morning is our executive director, Gord Gunning. I'll just give you a little background on the CANES organization, Gord will talk to some of the concerns we have and then I'll wrap it up. We'll try to keep it brief.

CANES Home Support Services is a not-for-profit health service provider, as defined in Bill 36. We have been providing services in central and northern Etobicoke for 23 years, and focus on providing home support services to seniors and adults with physical disabilities. We

offer a range of services, including personal care, respite care, caregiver support and counselling, supportive housing, homemaking, seniors' luncheons, home maintenance and newcomer elderly outreach. Our mission, as stated in our document, is to provide excellent support services for seniors and adults with physical disabilities to enable them to remain in their community environment in safety and dignity. We are active members of OCSA, the Ontario Community Support Association, and VITAL.

CANES is located in the Central West LHIN, which covers a large area, including northern Etobicoke, Malton, Brampton, Caledon, Orangeville, Shelburne and Dufferin county. Our catchment area covers seven planning neighbourhoods in northern Etobicoke, and the characteristics of our population of approximately 142,000 persons in northern Etobicoke include high poverty, high unemployment, a large immigrant population and a large percentage of single-parent families.

We believe that the implementation of the transformation agenda, including the move to create 14 LHINs throughout Ontario, will benefit our clients, our community and our unionized workforce. We also believe that Bill 36 will provide the government of Ontario with the mechanism to implement the transformation agenda.

We feel that there have been many province-wide attempts to restructure the health system in Ontario and that legislation is now required to provide the appropriate powers at the local level. With the legislative authority and associated funding, we believe LHINs will have the tools to effect change in the best interests of communities across the province. But we do have a few concerns that we would like to share with you today, and I'll ask my associate Gord Gunning to address those with you.

Mr. Gord Gunning: We've identified three basic areas in the legislation that we would seek some clarification on from you, and to consider in your clause-by-clause.

The first is community engagement. What will it look like, and will the community support sector have an equal voice at the table with the LHINs? The extent to which communities will be involved and consulted with respect to decisions about the local health system is referenced in Bill 36, but we are concerned that the details of that engagement are left to be addressed later by regulation, so we wanted to flag that issue. It is an issue with our colleagues through the Ontario Community Support Association.

Given that the stated purpose for introducing Bill 36 is to move toward community-based care and enable local communities to determine local priorities, we believe this matter should be addressed in the legislation and not left to the regulation-making process.

The second point is around health service providers, of which we're one, or will be under the legislation, if it's passed, and the proposed service accountability agreements, or SAAs, as they're referred to.

We're concerned that there's no model or standard accountability agreement at this point for the delivery of home and community care. We believe there should be a

requirement in Bill 36 to ensure that it is a centralized, standard accountability agreement, with some common outcome indicators or accountabilities for the whole sector so that there aren't 14 templates across the province, that there's one, and that they're based on goals articulated in a province-wide strategic plan, which the Ministry of Health and Long-Term Care is working on.

We believe health service providers should be invited to be an integral part of the process of developing these common outcome indicators. We have a concern that these could be developed in a head office environment, if you will, to go to the minister and then be rolled out to the LHINs without an opportunity for community engagement and input. We would prefer to have the community support sector invited to assist in the development of the outcome indicators rather than have them written into the regulations prior to an implementation process. That's point number 2.

The third one: As Velma has mentioned, we are a unionized agency. Bill 36 provides for an override to existing collective agreements. Just for the committee's information, CANES has a long history of bargaining in good faith with our union—that's Local 3808 of CUPE. We are now entering into negotiations for a new two-year agreement, which will be April 2006 to March 2008. So we have some concerns that Bill 36 could provide the LHINs with the power to override any agreement we might enter into in good faith with our unions at the time of bargaining.

As Velma mentioned, we view the legislation as a positive transformation agenda item that we think will benefit our agency and our workers going forward. We see opportunities for expanded contracts in the future, and that will be good for our workers. So we wanted to honour whatever agreements we enter into in the next couple of years.

We've got a couple of recommendations we'd like to leave with you as future food for thought.

The community support sector needs further investment in technology to ensure that we are successful in tracking and reporting what we expect will be both the financial and program performance indicators going forward with the LHIN service accountability agreements.

We believe there needs to be an ongoing commitment to clear and frequent communication, information-sharing and knowledge transfer from the Ministry of Health and the LHINs to the community support sector in order for us to develop the capacity to integrate service delivery within our defined communities.

Third, we believe there should be consideration of a mechanism to analyze the impact of the integration plans on a community-by-community basis, based on the patients and clients who will be served. If you were to take 2006-07 as a baseline year, say, then going forward, how is the implementation process working from a patient perspective in terms of their satisfaction index?

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Ms. Jones: Just to wrap it up, I'll give a short quote from Ted Ball, the then chairperson of Quantum Solutions. In 1995, he stated, "Until government has had time to develop a coherent strategic approach to the transformation of our public services, the only instrument they have available is a meat cleaver."

Seriously, as I stated at the commencement, CANES Home Support Services believes in Bill 36, the Local Health System Integration Act. We believe it will move the health sector into an integrated model that will better serve the patient and client. We think that if the legislation is implemented in a thoughtful, fair and resourceful way, the future health care needs of Ontarians will be met.

We believe that Bill 36, in combination with the re-organization planned for the Ministry of Health and Long-Term Care, will give the health system the tools it needs "to develop a coherent strategic approach to the transformation of our public services."

We know that not only our agency, but a majority of our colleagues in the community support sector, support the intent of this bill. The LHIN initiative has created a wellspring of collaboration, co-operation and communication within our sector and across sectors, as all health service providers attempt to grapple with the proposed integration.

At a recent visioning day on January 16, some 38 community agencies serving seniors in Toronto came together to discuss the health transformation agenda. This group identified a number of ideas for moving forward, including central access to services, developing infrastructure, integrating services and agencies, and exploring integration opportunities with other sectors, such as hospitals, family health teams, community health centres and community care access centres.

Our agency is actively involved in a service integration pilot project with three agencies at present, and also a back office pilot project with seven agencies. These projects are supported through funding from the Ministry of Health and Long-Term Care. The lessons learned from these projects will inform our sector on new opportunities for service delivery integration and back office efficiencies. These are just some of the examples of new collaborations that have started as a result of the transformation agenda. As you can see, we are rapidly moving with it.

If the Local Health System Integration Act passes third reading and receives royal assent, we will look forward to working with the new boards of directors and CEOs of the local health integration networks as we enter into a community engagement phase to develop an integrated service delivery plan for the Central West LHIN.

Thank you very much for hearing us this morning. We wish you all the best in your clause-by-clause review of the legislation.

The Chair: There is about a minute each for each group for questioning. Ms. Martel, please.

Ms. Martel: Thank you for your presentation this morning. Let me go to the section on community engagement because you and many others have said that the mechanisms for this should be clearly articulated and stated. Can you give the committee some ideas of how this should be approached?

Mr. Gunning: We're engaged in and we're supporting a process in the Mississauga Halton LHIN and central west LHIN—you may have heard of it—called Metamorphosis. It was started a year ago, almost a year and a half ago. It's following on from the initial workshops the ministry sponsored in terms of looking at local health integration. That could be looked at as a potential model where it has brought together all the sectors initially for some training and some information-sharing. We're now actively talking to the board chairs and CEOs of those two LHINs as to how that could be used as an example for community engagement with all sectors at the table. It's called Metamorphosis. There is a website and I can send you an e-mail on it, if you'd like.

The Chair: Ms. Wynne, a minute, please.

Ms. Wynne: Thank you for being here this morning. I just wanted to clarify the issue of collective agreements. This legislation doesn't invalidate collective agreements, but where there's a conflict between a collective agreement and a LHIN decision to integrate, there's a power to override just that section in order to allow the integration. So it's a very narrow power. I wanted to clarify that. It's certainly not the intention to override collective agreements holus-bolus. I just wanted to make that point.

Secondly, it's interesting that you've said that even in anticipation of the LHINs there is increased co-operation and collaboration. I've seen that in my own riding, where organizations are saying to me, "We're getting ready." There's that happening. Can you just elaborate on that a bit?

Mr. Gunning: I think it started in the central west LHIN with some of the initial forums bringing a broad range of sector providers together in Brampton, Mississauga, Orangeville. That was the start of a lot of us realizing we were operating in silos too. So seniors' agencies would collaborate with seniors' agencies, but we might not necessarily collaborate well with our mental health partners, our CCAC partners, our hospital partners and so forth. That was the start of it, kind of an eye-opener.

Ms. Wynne: That's great; that's very good news.

The Chair: Mrs. Witmer, please.

Mrs. Witmer: Just briefly, you've expressed concern that the bill is going to override any agreement that you might enter into. What do you think the consequence of that could be, if it did override that agreement?

Mr. Gunning: I guess the major concern, and it's hypothetical, obviously, at this point—

Mrs. Witmer: Yes, but we've heard that concern expressed before.

Mr. Gunning: I guess our concern would be that it wouldn't be just our local that would rise up against it, but it could be precedent-setting for all of the union or a variety of the unions that I'm sure you've heard from

directly. So in our world, we do have a lot of long-term loyal employees that we feel we treat fairly with wages and working conditions and benefits. I guess it's just more of an anxiety at this point, without knowing what the result might be.

The Chair: Thank you very much for your presentation.

Mr. Gunning: Thank you for the opportunity.

The Chair: Mr. Ramal, would you mind taking the chair, please?

FAMILY COUNCIL: EMPOWERMENT FOR FAMILIES IN ADDICTIONS AND MENTAL HEALTH

The Chair: The next presentation is from the Family Council: Empowerment for Families in Addictions and Mental Health, Betty Miller. Good morning. The Vice-Chair will chair for a few minutes.

The Vice-Chair (Mr. Khalil Ramal): Good morning. You can start whenever you're ready.

Ms. Betty Miller: Thank you and good morning.

My submission is brief. Sirs and madams, Mr. Chair, thanks so much for this opportunity to address the standing committee on social policy on the very important topic of the provincial government's health care transformation plan, specifically the development and design of the new local health integration networks, known as LHINS. I can only imagine the complexity of this ambitious and vital undertaking and wish you well in your upcoming endeavours.

I am the coordinator of a small—actually, a very small—membership-driven, incorporated non-profit organization. We are the Family Council: Empowerment for Families in Addictions and Mental Health. We are just under four years old and we have about 150 members. Each one is a family member or a loved one of someone who has received service or is receiving service at the Centre for Addiction and Mental Health, known as CAMH, or one or more of the family has received help from CAMH. We are funded by CAMH and we work pretty much exclusively with them on behalf of their clients and their families, but we have an independent voice. I am accountable to the membership and to my board of directors, all of whom are family members. I report on all of this to CAMH, but I am strictly accountable to the families.

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So it's an interesting and dynamic relationship we have with CAMH. We collaborate, sometimes loudly and not always smoothly, but we do indeed collaborate. Our mutual goal is to improve health care outcomes for clients and their loved ones. We are, if I may say, highly successful and skilled at this. We are results-driven, and the positive results are compelling. In the three and a half years of our existence, standards of practice have significantly increased. Furthermore, the costs for the increase are low, really low. It's a win-win situation.

CAMH has come to understand, from their own experience at integration and amalgamation, that families and patients or clients want in everywhere. We want to be engaged in the delivery of health care, from the design of the buildings to the delivery of services and programs, the creation of policies, evaluation instruments and, in fact, governance.

Perhaps it's a little overpowering to hear that clients and families want in everywhere in health care, but it's true; we do, and not just in Canada. In fact, our Canadian experience at including clients and families in health care is generally far behind countries like England and other EU countries, parts of Asia, Australia, New Zealand and the United States. Extensive research bears witness to the fact that when patients, consumers, clients and their families are actively and substantively engaged in the delivery of health services, you wind up with a higher standard of health care and more cost efficiencies. I have attached a seven-page bibliography in our submission to highlight this very distinctive and fundamental fact. Include families in a meaningful and substantive manner in all aspects of your process, and especially include clients. You will develop a better system. This has been proven. We cannot and should not be subsumed only within the context of community as stated in the legislation. Clients and families are different. We need to be partners, serious stakeholders and absolutely involved.

Families have provided unpaid and unsupported care to their loved ones—especially in the orphan child of health care, addictions and mental health—for centuries. The system would collapse if families and loved ones abandoned it. We know this intuitively. We know that families live the intimacies and obstacles of the broader determinants of health: housing, income, access to health care, education and justice. Families provide all of this and advocate for access to all of this, and really, this is just the tip of it. Yet, unless I missed something, the word “family” is not even mentioned in Bill 36—not once. Talk about a thankless and invisible moment in history. If you know anything about the incredible amount of health care we do, then perhaps you can understand why it hurts us to be passed over and go unmentioned.

Families have had to do this incredible amount of care because mental health and addiction services have been ignored and underfunded forever. This is true despite the myriad of government-led commissions and task forces and LHINs consultations that point out the glaring gap in the system and the chronic unmet needs of our people.

It's like the elephant in the living room. No one can get past it and no one talks about it, but it hangs over everything like a massive desert thunderstorm. It clouds and squashes words like suicide, schizo-effective, alcoholism, psychotic episodes, crack cocaine, accidental death, depression, hallucinations, delirium tremors and prescription drug addiction.

And we whisper to one another, “Who in your family? Who among your friends? Who in your workplace?” Do you know anyone with an addiction and/or a mental health problem? Of course you do. Certainly you do. We all do. This is the elephant in the living room.

You have probably already figured out that I am no expert on LHINs or Bill 36 or public health policy. I am here as the coordinator of a small, but provincial, family mental health and addiction organization. I'm also a family member and I'm also a consumer of services. So I won't embarrass myself by pretending any technical or sophisticated knowledge about the legislation or about the complexity of your assignment.

Suffice to say that I am here to persuade you to do a better job at including families in the legislation and to push the mandate of LHINs to address the issue of the chronic neglect of mental health and addiction services. As such, the Family Council offers the following recommendations:

(1) That families be acknowledged in the legislation as providing informal and crucial health care and as important stakeholders in the delivery of formal health care;

(2) That the development of a formal and ongoing consultation process with families and clients be mandatory in each region and not subsumed in a general process of community engagement;

(3) That the legislation mandates the establishment of an addiction and mental health advisory committee for each LHIN in each region;

(4) That small, local self-help and mutual aid organizations, consisting of client and family volunteers, be selected for protection from amalgamation with larger institutions;

(5) That the important contributions of regulated professionals, such as occupational therapists, recreation therapists and social workers, be given equal standing and recognition as that accorded to regulated health professionals;

(6) That the provincial government be allowed to withdraw their funding from organizations but not be able to force closure on organizations that receive funding from other sources.

The Family Council also acknowledges and supports the submission to this committee by the Family Mental Health Alliance.

These are my thoughts on the matter of LHINs. Thanks very much for listening. I'm happy to answer any questions if we have any time left.

The Vice-Chair: Thank you very much for your presentation. We have five minutes. We will divide it equally among the three parties. We'll start with Ms. Martel.

Ms. Martel: Thank you for making the presentation today and for the focus that you made, which was, frankly, different from all of the others that we've heard to date. Thank you for bringing the perspective of families, their search for health care, their need for health care and their need for participation.

I'm looking at the recommendations that you have made, particularly number 4. I think that's a very valid concern. In the legislation, which permits integration, there is a very legitimate concern that has been expressed by others as well that what will happen here is that smaller, particularly not-for-profit, organizations will be

swallowed up because someone will claim that the work they provide is a duplication of somebody else's work. With respect to point number 4—you've got a small, not-for-profit organization—what's the case that you can make for why it shouldn't be swallowed up or integrated because of the unique services that you're providing to families and clients?

Ms. Betty Miller: I think the small organizations are extremely cost-efficient, to begin with. Most of us are run 60% on volunteerism and volunteer boards of directors. You hire a volunteer coordinator and then you get 150 volunteers working for you. There's a cost-efficiency there that is locally based and community-based, so if a family phones or a client or consumer phones, they can receive service immediately, and in their own culture, in their own language. We are partnered with all kinds of smaller organizations. There is not a bureaucracy to go through.

If you phone one of the larger organizations today, most likely you'll get a voice message and you'll be lucky to get contacted in 48 hours. But with the smaller organizations, they're there; they're on the ground. They're run primarily by volunteers with a small staff. They will bend over backwards because they've been there. They're consumers, they're families. It matters to them that they're giving of their own time.

They're not duplicating service. On the contrary, when you receive mutual aid and support from somebody who is a mental health survivor, such as myself and hundreds of thousands of other people, then I think you're going to get good service. You're going to get it locally and quickly. It's not a duplication.

The Vice-Chair: Mrs. Witmer?

Mrs. Witmer: I think your presentation today probably is reflective of some of the wishes of people throughout the province of Ontario, who, seeing the introduction of this new level of bureaucracy called LHINs, have high hopes that some of their needs, obviously, are going to be reflected. The way it's presently structured, when you've got LHINs, some the size of 1.5 million people, it doesn't appear that organizations like yourself are going to have any voice unless there's a big change. There's certainly no process. Hopefully, the government will listen to your concerns. I want to thank you and I appreciate what you do on behalf of individuals and their families.

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Ms. Betty Miller: You can certainly contact the Family Mental Health Alliance if you want to talk about process and engagement. There are lots of recommendations for that and lots of us who would be happy to help with that one, for sure.

Mrs. Witmer: We hope the government will take those into consideration. Thank you very much.

Ms. Betty Miller: It's a pleasure.

Ms. Wynne: Thank you very much, Betty, for being here.

Following up on Ms. Witmer's comment, I want to reassure you that there are structures being removed from

the system, like the district health councils and regional offices, and the LHINs are being put in place. So it's not that we're building more bureaucracy; we're actually replacing structures with a new structure. Our hope in doing that is that we'll actually be able to connect with groups like yours and with the public.

You make a point about families that I think is really very germane. Here's the conundrum: Yesterday we had a presentation from a seniors' group, and I know we're going to have another presentation today. They would, for example, like to see a seniors' advisory council mandated. I know that other groups would like to see advisory councils dedicated to them. My concern is that we not create such an unwieldy process for LHINs that they're mandated to have 15 different advisory groups in place. I'm hoping that what we'll be able to do is have enough of a public engagement process that groups like yours will be part of the process *de facto* because it's a broad enough group.

I'm wondering about the family piece, though. Do you think that somewhere in the legislation there needs to be mention of families as one of the groups that at least should be heard from? Is that essentially what you're saying?

Ms. Betty Miller: Yes. One of the things I'm essentially saying is that families constitute a particular and specific and extremely important piece of this puzzle as providers, as receivers, as the underpinning in lots of ways, as we all know when somebody in our family gets ill. So yes, I think there needs to be a specific process to engage families in the consultation.

Ms. Wynne: As part of that broader public engagement process.

Ms. Betty Miller: I think you need to pull out this segment of the population, families, and consult with us—not just as broader, but as particular and specific and as regulated in the act. I believe that, and also, to address your other concerns about unwieldiness, yes, I think you could get unwieldy and at the same time I think some subcommittees or advisory committees are likely going to be necessary. If you look at your LHINs consultation across the province and the priorities that came out of that, one would think that those would be perhaps the priorities set for an advisory committee, seniors being one and mental health and addictions being another.

Ms. Wynne: I really appreciate your coming. I don't know that we're going to be able to meet all the requirements you're laying out; I'm just not sure we're going to be able to do that, but the fact that we've had seven days of hearings means we've been able to hear you, and I'm not sure we would have heard you if we hadn't done that, so it's very important. Thank you very much.

The Vice-Chair: Thank you very much.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 3202

The Vice-Chair: Now we have the Canadian Union of Public Employees, Local 3202, Toronto, Robin Miller and Peter Paulekat. You can start any time you want.

Ms. Robin Miller: Thank you. My name is Robin Miller. I am the president of CUPE Local 3202. With me is Peter Paulekat, national representative for the Canadian Union of Public Employees. Thank you for the opportunity to have the time to make this presentation to you this morning.

Local 3202 of the Canadian Union of Public Employees represents approximately 50 employees of Senior Link. Senior Link is a non-profit social service agency serving east Toronto for 30 years, assisting thousands of seniors annually to provide homemaking, home support, transportation, medical escorts, shopping, housing and advocacy. We provide a continuum of services to assist seniors to enable them to remain in their homes within their own community, rather than be institutionalized.

I would go through the history of our concerns regarding the timelines and how quickly all of this has come about, but I think everyone is quite familiar with that and I won't take up my time reiterating that to you. I would like to say, however, that we certainly would expect that in a democratic society, legislators have a broader obligation to the public and to public participation in the political process that would simply not allow a bill to proceed with this unnecessary and undemocratic haste.

The LHINs cover vast and very diverse areas. The LHIN boundaries have been formed in such a way as to override municipal and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent communities of similar interest. So it will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

The actual extent to which communities will be involved and consulted with respect to decisions about local health systems is referenced in Bill 36, but the details of that engagement are left to be addressed by regulation at a later date. Given that the ministry's stated purpose for introducing Bill 36 is to move toward community-based care and to enable communities to determine local priorities, we believe this matter should be dealt with in the legislation and not left to the less scrutinized regulation-making process.

The autonomy of the LHINs from the government is very modest. With this bill, cabinet may create, amalgamate or dissolve a LHIN. A LHIN is defined as an "agent of the crown," and acts on behalf of the government. LHINs are governed by a board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and vice-chair of those boards. Each member continues on the board at the pleasure of cabinet and may be removed at any time without cause.

The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose this even if the LHIN does not agree to the agreement. In addition, the LHINs' integration plans must fit the provincial strategic plan.

Where is the responsibility to the community? LHIN boards will be responsible to the provincial government, rather than local communities. This is in contrast with a long history of health care and social service organizations in Ontario, which as a rule are not appointed by the provincial government.

There are no provisions in the bill that ensure, require or even encourage LHINs, the minister or cabinet to preserve the public, not-for-profit character of our health care system or community-based social service providers such as Senior Link. Indeed, these bodies would now be armed with the legal authority to privatize large parts of our publicly delivered system. Moreover, LHINs will create a split between the purchasers of health care and social services and the providers. The LHINs will purchase services, and hospitals, homes, community agencies and for-profit corporations will provide them.

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Community care access centres, as an example, were originally comprised of community boards. It was not uncommon for these boards to be vocal proponents to the public regarding the need for adequate resources in order to ensure a healthy array and level of services within their community. This led to blunt criticism of the government in regard to underfunding, which resulted in privatization. The government's response to this was to replace the community boards with government-controlled boards.

CCACs were taken over by the provincial government in 2001. CCACs immediately ceased pointing out to the public their need for adequate funding. The result? Their funding was flatlined for years and home care services were cut back dramatically. Tens of thousands of frail elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 1, 2001, to April 1, 2003, and a cut of six million hours in services—a 30% drop. As one government report calmly noted:

“As prices went up and funding levels remained constant, CCACs had to discontinue certain services in order to maintain balanced budgets. These changes occurred independently without provincial coordination and clear communication. The emphasis shifted from homemaking services to the provision of personal support.”

Under CCACs' restructured referral process, coordinators no longer call service providers or organizations with new referrals. Referrals are spat out by computers to alternating agencies based on percentages. Thus there is no continuity of care.

This raises troubling concerns about the role of LHINs. Government-controlled regional agencies are a poor model for health care and social service reform. This, unfortunately, is the model for LHINs, and this is what we are facing.

LHINs are effectively flak catchers. LHINs will insulate government from decisions to cut back or privatize services by creating another level of bureaucracy that will catch much of the flak. The government will control

LHINs, but the LHINs will actually implement decisions. They will be the first targets for popular discontent, even if their actual autonomy from government is more imaginary than real.

The large, socially diverse areas covered by the LHINs also suggests there will be significant conflict over resource allocation. What services will the LHIN provide in each area of the LHIN? Unlike government, LHINs will not be able to increase revenue. Smaller communities may be the first to see their services integrated into other communities.

The LHIN structure puts up significant barriers to local community control of health care and affected community support services. Conflicts between communities within a single LHIN are likely, with small communities particularly threatened. Likely, the provincial government will respond to complaints by stating, “It was not our decision—it was a decision of the LHIN,” yet the LHIN will largely be unaccountable to local communities. These serious problems suggest that another direction must be investigated:

(1) We need to provide for the democratic election of LHIN directors by all residents in the LHIN geographic area, with selection of the chair and vice-chair by the elected directors. Local members of the provincial Parliament should be past directors of the LHINs.

(2) There should be a requirement in the bill for extensive public consultation on the existing geographic boundaries of the LHINs. LHIN boundaries should reflect real communities of health care and community-based not-for-profit social services interest, so that local communities can have a real impact on LHIN decisions.

(3) We also need a requirement for real public consultation when government proposes to amalgamate, dissolve or divide a LHIN.

(4) We need a commitment from the ministry to offer meaningful consultation with the community prior to imposing the agreement on a LHIN.

(5) We need to eliminate cabinet's authority to enact regulations closing LHIN meetings to the public.

(6) We need to ensure the right to seek reconsideration, and for full judicial review, by any affected person, including trade unions, of any LHIN, ministry or cabinet decision or regulation.

Another area of immediate concern for our members is the impact on bargaining units and collective agreements. The change in health care delivery contemplated by Bill 36 reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act, 1997, to many of the potential changes in employment that could result.

Health care and social service workers have been through many rounds of restructuring already, and we were always assured that the various changes were for the best. But too much restructuring simply consumed enormous energy and resources, exhausting health care and social service workers. Yet we face change on an even broader scale now.

We are not convinced that the government fully recognizes the can of worms it is opening. As the workers faced with this change, we deserve, at a minimum, a fair process that will provide reasonable employment security and protect working conditions, collective agreements and bargaining unit rights.

We are concerned that the Public Sector Labour Relations Transition Act may not be applicable in cases where the entity receiving the work is not a health service provider and where the primary function of that entity is not the provision of services within the health sector. This may allow LHINs or government to transfer work without providing health care workers the right to a union representation vote. We would also like to make crystal clear that employment security protections in our collective agreements cannot be overridden by this bill.

The Vice-Chair: Excuse me. Your time is over—if you have something to conclude.

Ms. Robin Miller: Bill 36 is an extremely complex piece of proposed legislation in and of itself, a complexity that is magnified many times over by virtue of the number of pieces of existing legislation that it amends. Given that the time allotment in these public hearings limits presenters to a maximum of 15 minutes, I have only focused on several key areas of concern for my members. Other concerns exist.

We believe this bill and the government's attempt to restructure health care and affected community-based social services needs to be rethought. We have made some suggestions that we urge you to seriously consider. I am sure that other presenters prior to me have put forth suggestions, and I trust you will be hearing more from those who follow. We had no sense before the last election that the government would embark on the path it has taken. We urge the government to consult local communities, health care workers, service agencies and the public in advance of making decisions of this magnitude. We believe these avenues would be very beneficial in assessing how health care should be reformed. That would be a much more satisfactory and democratic process.

I would like to thank the committee for listening to our concerns and suggestions.

The Vice-Chair: Thank you very much for your presentation.

BAYSHORE HOME HEALTH

The Vice-Chair: Now we have Bayshore Home Health. I believe we have with us Janet Daglish, Stuart Cottrelle and Stephanie Buchanan.

Ms. Stephanie Buchanan: Hi. My name is Stephanie Buchanan. I'm a clinical practice leader with Bayshore Home Health. I've been a provider in the community for the better part of 12 years, providing direct and indirect care. I'd like to thank the committee for allowing us to speak to Bill 36 today. I'd like to also introduce Janet Daglish, my colleague, and Stuart Cottrelle, our president, with over 20 years of community experience. Right now I'd like to turn it over to Janet.

Ms. Janet Daglish: I'm Janet Daglish. I'm director of community partnerships at Bayshore. I have eight years of community experience and 10 years in consulting.

At Bayshore, our goal is to provide quality service to CCACs in Ontario. It's for this reason that we're here today. Since his tenure as Minister of Health and Long-Term Care, the Honourable George Smitherman has created a strong vision for the health care system in Ontario. This has been reflected in the Local Health System Integration Act.

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To give a little bit of background about Bayshore so that you know where we're coming from, Bayshore is 100% Canadian-owned. We provide home care services in all provinces across Canada. We also operate two independent health facilities. We've worked with many regionalized health care systems in various provinces.

It's interesting that just recently the Conference Board of Canada published some research, which you may have been aware of. The most significant finding was that throwing money at a health care system does not necessarily lead to improved outcomes.

We feel that the LHIN model in Ontario is significantly different from other provincial systems and worth the investment of effort and resources. For example, one thing we applaud is that LHINs will not be providing direct health care services to people, but will be overseeing the strategic planning, funding and integration at the local health system level. This is the critical difference we find in Ontario that we want to ensure is supported through this legislation.

We provide home care services to over 12,000 Ontarians on any given day of the year. We become part of the community to meet individual needs of each CCAC client case load. We've built community partnerships in other provinces to ensure that we're really well linked with the local hospitals and other community support services. We want to continue to develop this relationship with the acute care sector here in Ontario. My position as director of community partnerships has been developed to support the promotion of integration initiatives between sectors.

Ms. Buchanan: I'd like to begin by saying that we agree with the concept of system integration focused on providing better service, more efficient service delivery and effective transitioning of clients from hospital to community, be it from hospital to long-term-care facilities or from hospital to clients' homes. However, our concerns lie with the process of community engagement, the planning process and the need to update the Long-Term Care Act to better reflect this government's vision for our health system.

Although we are a contracted provider to the CCACs, we are not considered a service provider under the current legislation. We are the nurses and personal support workers providing care to the clients. We are afforded the perspective of knowing the client's individual struggles, such as dealing with busy physicians, lack of physicians, limited system access and complex system navigation. In

light of this, we'd like to be actively engaged in the participation process.

Currently, we are not equal partners at the table. We would like to give feedback to the LHINs regarding clinical issues. For example, for elective surgeries such as hip and knee replacements, early discharge of clients into the community could be facilitated if we were involved at the point of admission, as opposed to being involved at the point of discharge, but this cannot happen if we are not participants at the planning table.

Ms. Daglish: I'd like to focus for a moment on the Long-Term Care Act. The Long-Term Care Act was introduced back in 1994 under an NDP government. The focus was to reflect an aggressive agenda to eliminate all community service providers and their boards, regardless of whatever their corporate status was. Section 4 of the Long-Term Care Act allows for the minister to provide direct community services.

At Bayshore, we've had experience in various cases before the Ontario Labour Board, and I've provided some examples in the written submission here, but basically, the cases focused on defining who the employer is, whether it be the CCAC or the service provider. These cases were dropped before precedents could be established. Significant funds have been poured into this issue at the labour board, dollars that could have been spent on community care.

We respectfully request that the Long-Term Care Act be reviewed and the definitions of "employer" and "multi-service agency" be redefined. The Long-Term Care Act must be cleaned up to reflect the 2006 vision of an integrated health care system and not a 1994 vision.

Basically, we have three recommendations that we bring to you today and that we'd like you to consider.

First, please engage community service providers working directly with clients in their homes in the planning process. We care deeply about the health and well-being of Ontarians receiving home care. We want to be part of the process of ensuring quality health care throughout the system as opportunities for integration are realized.

Secondly, we've found a discrepancy between the two acts with respect to definition of "employer" and "multi-service agency." We'd recommend strongly that this committee look at the implications to the labour board. This could have a significant effect on the cost to this government. We leave it with your experts to review. We'd be happy to assist as necessary.

Our third recommendation: Our focus today has been on community, but as an operator of two independent health facilities, we also feel that independent health facilities should be part of the LHIN system in order for this to work from a planning and a funding perspective.

Thank you.

Ms. Buchanan: Once again, we applaud the opportunity for health system integration. It is long overdue. We'd like to thank the committee again for the invitation to participate in community consultation.

The Chair: Thank you. There are a few minutes for each party for questioning. I'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation today. I wanted to focus on the independent health facilities, because it is true that they aren't part of this, and I'm not sure why that is. From your perspective, because you operate two, can you explain that rationale or give us some indication of why they should now be incorporated into the bill?

Mr. Stuart Cottrelle: Our two independent health facilities are dialysis centres, and 99% of dialysis in the province of Ontario is delivered through methods other than independent health facilities. It doesn't make any sense. If we're going to have integration, integrate the entire system, not just portions of it. To us, those independent health facilities should be part of that integration process. We offer great client outcomes, lower cost of care. All the LHINs that we've talked to are very interested in the model, but they're saying, "You're going to be outside of the LHIN model." We think it's important to have independent health facilities as part of it.

The Chair: Ms. Wynne.

Ms. Wynne: Having said that, do you see the possibility for your voice to be heard as part of the engagement process that each LHIN is going to have to undertake?

Ms. Daglish: We certainly would like to be at the table—invited to be at the table—as part of the planning process. We have many innovative projects that we've worked on with CCACs. We have tremendous experience in providing care to clients in their homes. We would like to be included so that we can build a better system together.

Ms. Wynne: And your voice is heard through the CCACs as well.

Ms. Daglish: Correct.

Ms. Wynne: Thank you.

The Chair: Ms. Witmer, please.

Mrs. Witmer: So you are a private provider, but publicly funded?

Mr. Cottrelle: Yes.

Ms. Daglish: Correct.

Mrs. Witmer: You feel that it would be of benefit to you to be part of the LHIN system, I hear you saying.

Ms. Daglish: From a system planning perspective, absolutely. You cannot plan for a health care system with integration unless all of the partners are at the table and are included in the planning process, or else you'll always have some disenfranchised part. It has to work together for this to be successful.

Mrs. Witmer: I would agree with you. In fact, we've heard from physicians. Part of the concern they have is that, as you know, they're not part of LHINs either, and they do believe there's a need for some sort of physician advisory committee. If you're going to have an approach where everybody is working on behalf of people in this province, you're going to all need to be at the table at some point in time.

Thank you very much for your presentation.

Ms. Daglish: Thank you.

The Chair: Thank you for your presentation.

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ONTARIO LONG TERM CARE ASSOCIATION

The Chair: The next presentation is from the Ontario Long Term Care Association: the executive director, Karen Sullivan, please.

Mr. Brent Binions: Hi. I'm not Karen Sullivan.

The Chair: Could I have the new name?

Mr. Binions: Unfortunately, Karen is caught in traffic and probably will be here just as we finish this process. I'm hoping that the presentations she has with her will arrive within five minutes, and we'll pass them around when they get here. My apologies.

The Chair: There is no problem. We can always get it later on.

Mr. Binions: My name is Brent Binions. I'm a member of the association, the vice-president of finance. My apologies for not having the information in front of you, but I know things have to proceed on time, so away we'll go.

Good morning and thank you for hearing our presentation today.

The Ontario Long Term Care Association represents the private, not-for-profit, charitable and municipal operators of 428 long-term-care homes that provide care and services to some 49,500 residents throughout the province of Ontario. Although we're more well known for representing almost all of the private sector operators, most people do not realize that we now represent about one in four, or 25%, of the not-for-profit sector. In nearly all cases, these operators have decades of experience in working with the community to deliver a provincial program on the government's behalf. As a result, our comments on Bill 36 address the opportunities, concerns and solutions for residents and operators in all types of long-term-care homes in the province.

Let me state at the outset that we support and are encouraged by the potential and the vision of the goals of Bill 36. A more integrated, resident-focused system of health care delivery is something that all of our members hope for. For this vision to be realized, however, it has to work for all health service providers, including the province's 630 long-term-care homes. Right now, we have some concerns that it may not. Instead, it could create some risk of inequities and instability in the delivery of the provincial long-term-care program, and the potential for costly confusion and duplication in various areas related to program delivery. We believe this was not necessarily the intention and that these issues can be fixed, and we are here today to propose solutions. A full and detailed list of our solutions is contained in the written submission that we have for the committee.

Bill 36 is about the delivery of health services. In your hearings in London and Ottawa, you have heard from our members, both private and not-for-profit, that in the long-term-care sector, our services are in fact our beds. We receive a per diem—or per-bed funding—rather than

global funding like most other health service providers under this legislation. Unlike for others, this per diem is a combination of funding from the province and from the residents themselves through a copayment. As a result, our residents and their families have an expectation that the services will be the same regardless of the type of operator or the location of the services.

Control over beds equals control over service, and currently that control rests with the Minister of Health and Long-Term Care, who issues a licence to private, not-for-profit and some charitable homes for the number of beds they can operate. The other charitable and municipal homes operate the number of beds approved by the minister. Operating funding is determined by the number of licensed or approved beds. So too, then, is the amount of service a home can provide. In the case of licensed beds, there is also a direct link between the licence and the financial community's decisions to approve and renew mortgages, and the terms under which they do so.

We believe it is appropriate that the ultimate control over a provincially standardized care program that provides care and services to the most vulnerable members of our province rests with the minister and not with the LHINs. We believe the ministry agrees and that this will continue to be the case under the new long-term care act, which we understand is coming soon.

It is critical that there be consistency between Bill 36 and both the current and emerging long-term-care operating environment. This may not be the case, however, because Bill 36 in its current drafting devolves authority for service to the LHINs. Part IV, section 20, provides no assurances that LHINs will fund all of a home's licensed or approved beds. To maintain service access, equity and stability in communities across Ontario under the LHINs, we urge changes to Bill 36 requiring LHINs to fund homes consistent with their provincially licensed or approved bed capacity, utilizing a standardized funding framework with built-in accountability. Specifically, part IV, subsection 20(1) should be amended by adding "where a health service provider is a long-term-care home, the service accountability agreement shall provide funding for the home's total capacity of licensed or approved beds."

Section 20 goes a step further by adding an additional risk that no funding could be forthcoming at all. It specifically indicates that payments "may" be made rather than the current language in the Nursing Homes Act, which says they "shall" be made for the services that are actually provided. Since we're paid in arrears, that creates a greater risk for us. It is not likely the intention of the government that they abandon their responsibility to fund this vitally important health care program, so we question why the change in language to allow for this risk to occur.

Centralized funding tied to provincially licensed or approved bed capacity provides a base for homes to pursue the opportunities to provide local solutions without compromising core service delivery. We already see examples of this with initiatives such as the recent

provincial program to convert 340 long-term-care beds to convalescent beds to help move patients out of hospitals. It is key that the funding provided for this program was an addition to the base funding for those beds. Other types of specialized programming could be offered by long-term-care homes, based on local identified needs and negotiated by the individual LHIN and the long-term-care home. We would encourage that a fair, transparent and consistent process be utilized to determine the most appropriate provider of these services.

Over the past few days, we have watched with interest the reaction of others to the section on minister's orders. Many groups would have you believe that the solution is to include the private sector under section 28 for fairness and equity purposes. Currently, long-term care is in fact the only health service provider covered by the legislation that includes the private sector. So that reference in section 28 of the bill is to long-term care. Including us in section 28 is somewhat redundant since it's already been established that the minister has, and will continue to have, control over licensed and approved beds under long-term-care legislation. The real solution isn't to add the private sector to section 28, but to exempt all licensed and approved long-term-care bed operators from the section, because that control already rests with the minister and you can't have two agencies controlling the same entity. We believe providing that control as well to the LHIN is redundant and could cause conflicts.

Accountability is a major focus of Bill 36. Here again, we believe improvements are required for alignment with both the current, and shortly anticipated, long-term-care reality.

Specifically, this bill creates the potential for two parallel accountability processes: one from the local service accountability agreements between the LHIN and the operators, and the other provincial from a standardized compliance and inspection program we have every expectation will be continued under the new Long-Term Care Act. If that's allowed to occur, we would have confusion, more bureaucracy and increased costs.

This potential can be eliminated in Bill 36 with provision for a single and consistent service accountability agreement similar in concept to the existing standardized service agreements between the ministry and the homes. We ask that the committee add language to part II, subsection 20(1), and part IV, subsections 47(7), (8) and (21), to ensure this standardized agreement is developed in regulation.

Further, we ask that sector associations be consulted in the development process. We could help ensure that the agreement accommodates our various governance structures, be it private operators, not-for-profit and charitable boards and municipal governments.

Accountability for local specialized services can then be accommodated by adding amending agreements between the LHIN and the individual providers in order to provide whatever services are needed locally.

Just as our multi-governance structures have implications for the application of Bill 36, so too does the fact

that over 60% of long-term-care homes in Ontario are operated by multi-site organizations. In many instances, these organizations span LHIN boundaries.

Internally, they have already achieved many of the elements of the ministry's vision of back office integration. This would include everything from group purchasing, which is standard across our sector, and shared management and professional resources to information technology platforms and payroll systems.

In many organizations, this integration also incorporates functions beyond long-term care and beyond the scope of Bill 36. For private, not-for-profit and charitable operators this could include retirement homes, assisted living, life lease, home care services, supportive housing services. For municipal operators, it includes municipal fire and police departments and services, among others.

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As currently written, the broad definition of "service" in part V, section 23, will directly impact on these internal integrated processes and functions. If LHINs begin to exercise the full authority that now exists in this definition, they could create significant business and operational issues for all multi-site providers, issues that will have the opposite of the intended effect and could actually increase inefficiency and costs.

We therefore urge that this risk be removed by changing the language of part V, section 23(c), to exempt the functions that support the operations of licensed or approved long-term care beds from the definition of "service."

I would like to wrap up my remarks this morning by commenting on transparency. It is fair to say that Bill 36 has the potential to create significant change, provincially and locally. It's obvious from the presentations to this committee that the expectation of that change is creating a significant amount of angst. While the long-term care association supports the overall direction of this bill, we believe that individually and collectively our members share some measure of this concern. As Bill 36 is implemented and LHINs begin to function, the potential for this concern to grow or dissipate will be significantly determined by the degree of transparency in the LHIN decision-making and operating processes.

Bill 36 speaks to this now, but it does so in ways that leave many unanswered questions. We accept that some of those answers will occur with actual experience; however, we believe that there is room for improvement and clarification within the legislation.

For example, community engagement is currently very loosely defined in terms of who and how. Further definition would add transparency to ensure that providers, who already have limited administrative resources, have an equal opportunity to participate in service integration, and that the process is accountable.

Similarly, we think a lot of the current concern relates to a lack of assurance of transparency in the decision-making process. The assurance of transparency can be further supported by language in part II, section 9(3), to ensure that the conditions under which a LHIN board can

hold in-camera hearings are defined in regulation. It's critical that key decisions, particularly those related to service integration, not be made behind closed doors. This would include the opportunity for parties impacted by an integration decision to have the opportunity to present their case for reconsideration in a public board meeting.

In closing, we would like to say that we understand that Bill 36 is a bold initiative and that it will bring change. In those changes, we see a potential to move closer toward our capabilities to make a larger contribution to a more effective and efficient health care system. It's clear, however, that we need some changes to recognize the realities that the public expects, and that the ministry continue to signal through other initiatives that basic long-term care in Ontario is a universal program in order that its full potential be realized.

We thank you for listening to us today. I will answer any questions.

The Chair: There is about a minute left. Ms. Wynne, 30 seconds, please.

Ms. Wynne: Section 20—I just wanted to check. Country Terrace in London and Specialty Care Granite Ridge in Ottawa I believe came forward with the same recommendation.

Mr. Binions: That's correct.

Ms. Wynne: Okay. Also, on section 47, are you suggesting—I apologize; I didn't have the written piece.

Mr. Binions: I apologize.

Ms. Wynne: Service accountability agreement: Are you suggesting that is where the amendment should be? You're looking for a consistent accountability agreement?

Mr. Binions: We're looking for a requirement that the agreement be standardized for the base services. Beyond that, they can be changed by the LHINs to add any other services.

Ms. Wynne: Just quickly, the problem if they're not?

Mr. Binions: The risk, if they're not standardized, is that we could get into about 14 different service agreements across the province, with different rules for the provision of exactly the same service that the resident is paying exactly the same amount for.

The Chair: Mrs. Witmer, please.

Mrs. Witmer: Thank you very much for your excellent presentation. What would be your overriding concern? What is the one amendment that absolutely must happen for you to be able to continue to provide the services in an integrated fashion?

Mr. Binions: I guess our overriding concern is around the issue of licensing and funding. We believe that the ministry has structured a program that's consistent across the province. It is licensed, and therefore controlled, by the Ministry of Health. If you were to devolve the funding separate from the licence, it would mess up the system tremendously. That would be our biggest concern.

The Chair: Ms. Martel.

Ms. Martel: Just to be clear, the money remains with the minister. It's not devolved to the LHINs to then pass on to you.

Mr. Binions: What we're asking for is that the funding for the core services of long-term care be mandated. If we have a standardized program, we ask that that portion of it be mandated to be delivered as it is now through the LHINs, but anything beyond what the LHINs want in a local service be a separate pot, and they can add in. They would contract directly with the homes on that.

The Chair: Thank you very much.

TOWNSHIP OF SCUGOG

The Chair: The next presentation is from the township of Scugog: Her Worship Marilyn Pearce, Dr. Bill Cohoon and Bette Hodgins. I apologize if I didn't pronounce it properly.

Ms. Marilyn Pearce: Chair and members of the social policy review committee, on behalf of my community, the township of Scugog and the residents of North Durham, my colleague Dr. Bill Cohoon and I thank you for the opportunity to speak to you about Bill 36. I would like to address the whole issue around local community input to the LHIN's decision-making process and to the provincial strategic plan on which your decisions will be based, as I believe good two-way communication is important during a time of such systemic change. Dr. Cohoon, who is with me, will be available, should you have any questions about the delivery of rural health care.

The township of Scugog is definitely a rural community in the northeast part of the GTA, entirely within the greenbelt planning area and north of the Oak Ridges moraine. We are an agriculture-based economy. Port Perry is the major urban area, and in Port Perry, there is a 20-bed hospital that is part of the Lakeridge Health Corp. Since the formation of that corporation in 1997, there have been numerous changes to the services in Port Perry—some good and some not so good.

It is important to note, though, that this hospital services a very large rural area to the north, including parts of Brock township and the city of Kawartha Lakes, as well as a First Nations community, the Mississaugas of Scugog Island. As such, it also services a significant tourism population, as the Great Blue Heron Charity Casino attracts over a million visitors a year.

It is also home to a rural residency teaching program in co-operation with the University of Toronto. This program has been in effect for about five years and trains doctors in all aspects of rural care. In fact, it has just adopted a first-of-its-kind rural health services program for Lakeridge Health.

Why, then, are my residents concerned about this bill and the creation of local health integration networks? I would suggest history has a lot to do with our concerns. Since 1998 and the last hospital restructuring, the loss of local control has become a way of life. Trying to understand the process by which residents can have input into hospital care changes has become frustrating and at times emotional. LHINs must allow for better stakeholder communication and local consultation before decisions

are made. The bill needs to address these issues, and I don't believe it does.

Changes in health care delivery and the devolution of decisions from the minister's office to the LHINs is something that needs clear rules around transparency of action and appeal mechanisms so that the residents of the local area can at least have an opportunity to ensure that all aspects of the decision have been weighed.

Our local area, as defined by the central east LHIN, has a huge geographical area to service. I believe it is the second-largest LHIN, with an area larger than the province of Nova Scotia and a rather complex mix of urban hospitals, rural areas and even isolated communities, stretching from Scarborough to Algonquin Park. Nova Scotia, by the way, has five networks for that area. It does give new meaning to the word "local." Having said that, it also has the complexity of numerous hospital corporations, health care providers and boards, all with different strategies about service delivery.

The provincial strategic plan, which includes a vision, priorities and strategic directions, is part of Bill 36, and that is welcomed. What isn't clear is how the public, the consumer, will be involved in setting the priorities for that strategic plan.

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Good stakeholder communications require that the consultation take place before the decisions are made and that communities have an opportunity to digest and discuss issues in advance of decisions. The creation of LHINs boards should be an opportunity for the public—the actual consumer—to have effective communication with the board responsible for funding decisions. It should also allow for decisions affecting a community's hospital and health care to be open to appeal. Who becomes the community advocate, as the LHINs board is not elected but rather appointed?

The rules around meetings should be clearly defined. Simply posting integration decisions on a website after the decision has been made is not acceptable, especially since the only appeal is by the health-care-provider party to the decision. Shutting out the general public will have huge consequences, from hospital fundraising and community commitment to health care agencies. Health care costs could actually rise as public resentment is expressed in the withholding of donations and volunteerism. If we really want this new model to work, clearly define who the public is and that they have a right to appeal if the funding envelopes that the LHINs designate are inequitable or unmanageable. What sort of accountability will these boards have to provide that all communities needs are being met, not just the large, powerful urban areas?

There are some who may argue that the LHINs will create another level of government bureaucracy, and they may, but I would hope that by dissolving district health councils and regional offices, the government in fact is streamlining and clarifying roles and responsibilities and allowing for the devolution of authority. But for that to happen, changes to the bill are required. The list of major

providers of primary health care does not include family doctors, dentists, laboratories and public health. How can we achieve an integrated health care system without them?

Back to my community, though, and the 30 years of integrated health care we bring to the table. Our family doctors, in co-operation with Lakeridge Health, have developed a vision for primary rural care that could be a provincial model, but under this bill, those ideas may be lost. True integration of care across traditional barriers needs the family physician to be part of the equation. Rural health care that is family-practice-focused and led and that includes the support services in the general specialties such as general surgery, internal medicine, and outpatient consultation and surgery is a template for other rural communities in this province. But how can that be accomplished without family practitioners at the table? In my opinion, the present model of health care integration is in fact hospital-based. Amend the bill to include a broader range of health care providers. Leaving family doctors out is a mistake. Setting up effective community advisory groups that include community representatives as well as family physicians and nurses would resolve some of the resentment and mistrust that surrounds the creation of these new boards.

Finally, the funding of the new LHINs is a real issue for my community, as we are part of a LHIN with a huge deficit. How will the government fund the new boards—from a new-beginning position or from a transfer of old funding problems to a new entity that is still underfunded? The last hospital restructuring did not really address a flawed funding formula, and we must do better. Bringing forward all the former debt will create huge battles between communities, just as amalgamation of former municipalities has. Form must follow function, not lead it.

In summary, I believe that Bill 36 should be amended as follows:

(1) The provincial strategic plan should include a primary rural care vision, and family doctors should be part of that exercise. Public input to the provincial strategic plan needs to include the general public and true dialogue prior to the minister adopting the plan.

(2) Any decision that affects in a significant way the health care of the people in a community must be subject to appeal by the general public. Determination of what is considered significant is needed. Is it the loss of beds, the loss of a service that is critical to community health care stability or is it the distance that the sick and elderly must travel for care? Will travel times be considered along with wait times? In the central east LHIN, distances and weather conditions can be great problems.

(3) LHINs must be open to the public, and clear rules around when a meeting can be considered in camera need public debate. Transparency and accountability to all residents and users of our health care system are required. Minutes of those meetings should be posted on the website. We would also request that timelines on the posting of an issue to be discussed at LHINs meetings be

available at least two weeks prior to the meeting and that LHINs board meetings be moved around the various local communities, as driving distances in the central east LHIN are significant. This will truly bring decisions closer to the local communities they represent.

(4) The governance role of the present hospital corporations and their relationship to LHINs needs to be better defined. My community has already voiced to the minister our concerns on how these corporations carry out business. I believe we are not the only community across this province expressing non-confidence in the present model and its lack of consultation and transparency to the public.

I hope that as a committee, you will listen to the public. In many of the presentations I have heard, the same thing is being stated. There is a real fear in the communities that local control is being further eroded. As a community that prides itself on financially supporting our hospital, our community health care providers and our physician recruitment and doctors, any further erosion of having consumer input in the services being delivered and the decisions being made could have significant consequences. Thank you.

The Vice-Chair: Thank you, Your Worship. We have about five minutes. We'll divide it equally between the three parties. We'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much. I'm quite impressed with your presentation. I guess your comprehension of what's contained within the bill is certainly reflective of some of the other voices of concern and interest that we've heard.

You mention here that there is a fear that you're reading from the public in presentations that local control is going to be eroded. I would agree with you. I think there is genuine concern, because when you have LHINs that are the size of the central LHIN, for example—one and a half million people—I don't think you're going to know many members of that board; even in the smaller LHINs, you're not going to.

What do you think is most critical in order for these LHINs to clearly understand the will and desire of communities and be able to reflect that in their planning?

Ms. Pearce: I think it is a real need for advisory committees at lower levels of consumers and doctors, as I've stated. Rural communities are very close to their doctors. They are the front line, they're part of the community. There's a tremendous trust in the medical profession, the family practitioner. You talk about me being well versed; it's because the doctors certainly keep me well versed in all the issues around health care. I think, especially in the large LHINs, there has to be a role for rural advisory committees, and you have to get back to the people, to the consumer, before you make decisions.

Mrs. Witmer: So you're suggesting a number of different advisory committees that would report to the LHIN organization, the board?

Ms. Pearce: I think they have to take advice not only from the health care providers but also the consumers, and you can do that through advisory committees.

Mrs. Witmer: Okay. Thank you very much.

Mrs. Maria Van Bommel (Lambton-Kent-Middlesex): Thank you for your thoughtful presentation. As a member who represents a fairly large rural riding—it's actually 92% the size of PEI—I certainly understand the concerns about delivering health care to rural communities. I want to just go a little bit further. You talk about a rural advisory committee to the LHIN. Wouldn't it be better—you also mentioned in your presentation things such as elected versus appointed. I know that in one of the LHINs within my riding, five of the six appointees to the LHIN are rural. If we were to go to an election, I'd be more afraid that the urban part of that LHIN would probably weigh heavily in what the structure or what the appearance of that LHIN would be. I think being able to appoint rural people to the LHINs is more important sometimes than getting an election. Do you think that having appointees to the LHIN itself who have a good strong rural background is better than even having a rural advisory?

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Ms. Pearce: No, I still think there's a role for a rural advisory. But I don't think our community would have any difficulty in the appointing of the LHIN members. In other words, we have not been totally comfortable in a multi-site urban-rural with how hospital corporations elect members, because that situation you explained is exactly what happens. I don't think there's any doubt that we hope that those in the position look at that rural mix that's required and do the appointment.

What I'm suggesting, though, is that the LHIN board itself cannot get their only advice from the more well-organized health care providers who might be in the more urban areas. They also have to hear from those rural communities. You take any hospital corporation that's in a rural area and you look at a whole system whereby that community makes their concerns known directly to the health care provider about the level of service they want.

I find, especially in rural communities, if you were to look at a per capita funding of us giving to the local hospital, I'm sure it's much higher than it is anywhere else. In fact, we're looking at a major campaign at our hospital right now, and the municipal governments will probably be on the hook for a third of that campaign. But if we have no say, if we have no way of making our concerns known, I'll tell you, that will dry up very quickly.

How do you get that advice? How do you hear from the community? I'm not talking about the people who are necessarily even consumers of the system yet. They're just the people who may be consumers of the system in the future. How are you going to hear from them if you only hear from the providers?

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for driving here today. I was in the Port Perry hospital early in December with one of your councillors and I appreciated that visit. I was struck by two things: first, the level of effort that had been made with many partners to provide a broad range of services

in the hospital, clinical services and services that traditionally might be outpatient but would be hard to access somewhere else because of distances. I was very impressed with the myriad of partnerships that had already been established for a broad range of services. Second was the commitment of the community to the hospital. You've got a long list of community involvement in terms of various campaigns, fundraising and how much money had been raised, both from individual citizens and then the portion that was put in by the municipality. So I had a very clear sense of people's attachment to the hospital.

This leads me to this particular question. This LHIN is very large. There are major centres. I come from a LHIN that runs from the James Bay coast right down past Parry Sound: 34 hospitals. When we hear terms like "integration," "transfer," "amalgamation," we see that as smaller hospitals losing their services to a larger regional centre. There are 34 hospitals in our LHIN, and the fear is that those services will go to North Bay, Timmins, Sault Ste. Marie, and some of the other services just directly to Sudbury, which is already the regional centre.

Given the commitment that your folks already have and given the changes you've already seen with restructuring, which have been very significant, should you be worried and are you worried about the potential in this bill to see even more services move to larger regional centres at the expense of smaller community hospitals like your own?

Ms. Pearce: Yes, we are. One of the concerns—and Dr. Cohoon might want to speak to it—is that people really underestimate the requirements around a rural residency program that operates in co-operation with our hospital and our medical associates but offers a full range of services. If you're going to train doctors in rural health care, they have to know, if they're in a rural setting, not only how to deliver a baby but how to do a bit of general surgery. They have to know a whole realm of things. We can train people like that in our hospital. Sometimes, when you're just looking at the numbers, you don't realize—it's, "Well, we might as well cut obstetrics, because they only do 350 births a year. They should take it to a bigger site." What happens, though, is if you cut that, you cut the rural residency program. When you cut the rural residency program, you cut the training of rural doctors—fairly close to Toronto but far enough away that they still feel like they're in a rural area. If you cut that training of rural doctors, you get down to a whole system where doctors who want to move into rural areas, wherever they are, then don't have a full range of training.

Each one of those little cuts—they look little—is a domino effect that impacts the whole hospital. They impact whether we have a surgeon now, because if you take away the little bit of obstetrics, you take away some of the general surgery and things that accompany that. So if you do that, it has a domino effect. Sometimes you can't make that position very clear to big hospital corporations that simply say, "Sometimes in our mind bigger

is better, and this is how you fix it," when in fact you can offer those services closer to home in a rural integrated model that works.

The Vice-Chair: Thank you very much, Your Worship.

ALLIANCE OF SENIORS

The Vice-Chair: Now we have the Alliance of Seniors: Derrell Dular, coordinator, and Jack Pinkus, past president. You can start whenever you are ready.

Mr. Jack Pinkus: Good morning. First of all, I'd like to thank the committee for giving us the opportunity to express our views on Bill 36. My name is Jack Pinkus. I'm a member of the executive committee and past chair of the Alliance of Seniors. Along with me is Mr. Derrell Dular, our executive director.

I first would like to go on record saying that this brief submission reflects only our personal thoughts and those of the Alliance of Seniors and their affiliate organizations.

Now some background about the Alliance of Seniors: Founded in 1993, the Alliance of Seniors is an active, diverse and growing non-partisan coalition of individuals and organizations representing over 300,000 older adults residing mainly in the greater Toronto area.

Our mission is to preserve and enhance Canada's social programs on behalf of present and future generations, so it's not only for seniors; to promote a society where all persons have an equal opportunity to realize their potential, to participate in a democratic society, and to live with dignity; and to educate the general public in the greater Toronto area about the concerns of older adults.

The Alliance of Seniors participating organizations include the Association of Jewish Seniors, Bernard Betel Centre for Creative Living, Canadian Institute of Islamic Studies and Muslim Immigrants Aid, Canadian Pensioners Concerned, Care Watch, Caribbean Canadian Seniors, Concerned Friends of Ontario Citizens in Care Facilities, Congress of Union Retirees of Canada, Elder Connections, Habayit Shelanu Seniors, Jamaican Canadian Association, Korean Inter-agency Network, Older Women's Network, Ontario Coalition of Senior Citizens' Organizations, Ontario Federation of Union Retirees, Ontario Health Coalition, Riverdale Seniors' Council, Toronto Health Coalition, Toronto Seniors' Assembly, and Yee Hong Centre for Geriatric Care. So, indeed, it is quite diverse.

The Alliance of Seniors, its affiliates and friends endorse the principles of the Canada Health Act: comprehensiveness, universality, accessibility, portability, and public administration. We are concerned that under the proposed Bill 36, as stated in the preamble, the government of Ontario and its Ministry of Health and Long-Term Care are held only to govern and manage the health system in a way that reflects an undefined public interest, efficiency and high quality.

Now I'll turn it over to Derrell.

Mr. Derrell Dular: Our presentation, with your indulgence, is of a general nature because for the past year many of our affiliate organizations have expressed a great deal of concern and studied quite thoroughly the provisions of the proposed Bill 36.

We have many concerns. We're concerned with the obvious disconnect between the otherwise admirable preamble and what appear to be the onerous provisions of Bill 36. We fear that something has been lost in the translation. There appears to be a substantial difference between the letter and the original intent.

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In the name of efficiency, the provisions extend the questionable competitive bidding process and exhibit, we believe, an ideological bias against not-for-profit, community-based and user-sensitive service providers in favour of for-profit market privatization and the corporate-industrial model of service delivery.

There appears to be little public accountability and even less provision for democratic input, as some of our previous presenters have mentioned, for community control or for a fair appeal process of decisions made by either the local health integration networks or the minister himself, regardless of the impact on communities, families or individuals.

There is no protection against the arbitrary reduction or complete withdrawal of various health services provided currently under the Ontario health insurance plan.

Bill 36 seems to centralize, rather than regionalize, control over the health system, with all control going back to the minister. There is no provision for adequate public scrutiny and input into the formulation of the crucial strategic plan which will determine the very nature of health care in Ontario.

Bill 36 represents the second major restructuring of health care in Ontario in a decade. Like the previous Conservative government's hospital service restructuring, there appear few checks and balances to ensure real efficiencies and improvements in health care delivery. However, with the establishment of a cumbersome new bureaucracy, there will be an obvious increase in administrative and legal costs that will divert significant money from the actual provision of quality health care services.

Finally, we are very concerned about the possible unintended legacy of Bill 36 and its implicit increased centralization of power and authority in the present government. Would a successor government use it well and in the greater public interest?

In the best interests of all who would be served, we, the Alliance of Seniors, request that the government of Ontario withdraw Bill 36 pending substantial revision. Thank you.

The Vice-Chair: Thank you for your presentation. We have about four minutes left. We'll divide it equally among the three parties. We'll start with Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. A couple of things. I want to ask you first about the unintended legacy of Bill 36 and the increased

concentration of power that you speak about. In fact, what we're trying to do is exactly the opposite of that.

I just want to read a quote from the minister in the Daily Press in Timmins today. "The (local) mayor ... will be able to pick up a phone and speak directly to the LHIN director," he said. "Where before they would have to hope that their local MPP would be able to get them a meeting with the health minister."

I guess the point we're trying to make, and I'd like you to comment on it, is that right now we've got a centralized bureaucracy in Toronto. We're getting rid of district health councils, and that planning function is going to the local health integration network. We're dismantling the regional offices, and those functions will be absorbed into the local health integration network. And then \$21 billion which is now basically allocated from the centre, from the ministry, is going to be in the hands of the local health integration networks and in the hands of that person that the mayor can pick up the phone and speak to. I just don't get how that's centralization. To me, that's decentralization and that's engaging the public. That actually, to me, is the check and the balance on a subsequent government trying to change that structure, because the public will be more engaged. Could you comment on that?

Mr. Dular: It appears from our reading of the provisions of the bill that there is not an adequate appeal process. Local representatives, politicians, may be able to pick up the phone and address a particular individual about their concerns, but there's no provision that that individual, upon hearing those concerns, will actually act on the concerns raised.

Ms. Wynne: But how is that a different or worse situation than we have now? We're trying to improve that engagement.

Mr. Dular: I don't think it's necessarily different or worse than what we have now, but I don't think it's substantially better.

Ms. Wynne: Except that you have that connection that's not there now—that would be the improvement, from our perspective.

Mr. Dular: I guess it's the element of, "It's okay. Trust me."

Ms. Wynne: We're trying to make structural changes that would actually put the change in place. The other thing is that there's nothing in the bill that extends competitive bidding, so I just wanted to make that point. There's nothing in the bill that does that.

Ms. Martel: Thank you for being here. Of course, there's nothing in the bill that prohibits competitive bidding either; there's no particular amendment that says that the LHINs will not use competitive bidding to acquire the services in their LHIN area. I've challenged the government: If they mean what they say, then they will bring in an amendment and say very clearly that competitive bidding is not going to be used.

Here's my concern. Let's be clear: The LHINs are not accountable to the communities they're purported to serve. That has been the big joke about the legislation.

The minister would like to say that this is about community control over all of this money. If you look at the legislation, it's very clear that the minister controls the LHINs, not the community. The minister creates, amalgamates or dissolves the LHINs. The LHINs are appointed by the minister. The chair and the vice-chair are appointed by the minister; they serve at the minister's whim for as long as the minister decides that's going to be. The LHIN is explicitly defined as an agent of the crown right in the legislation. Each of the LHINs enters into an accountability agreement with the ministry about what they do; there's no similar accountability agreement with the community that they're purported to serve. The LHINs are funded by the ministry on the terms and conditions that the minister considers appropriate. The LHINs have to develop an integrated service plan, but that plan has to be consistent with the provincial strategic plan, and we don't even know who's involved in the development of the provincial strategic plan at this time; we certainly haven't seen it, and we haven't found any groups that are actively engaged in its development right now either. So to say that this is all about money going to the community and the community making decisions is just ridiculous.

In terms of the concerns you've relayed—and I noticed that you're not a group of folks whose jobs are going to be impacted, so you're not some of these union yahoos who the minister would like to portray as only coming here and providing us with misinformation because their jobs are going to be affected. You've done a pretty clear analysis that says, "Jeez, we're concerned about competitive bidding; we're concerned about the disconnect between the preamble and the onerous provisions of the bill." You even suggest that it should be withdrawn. Is there anything else you want to comment on in terms of your concerns with this bill from a group which isn't actually impacted, because your jobs aren't even on the line here?

Mr. Dular: Thank you for so articulately expressing so many of our concerns and reasons why we arrived at our particular conclusions. In Mr. Pinkus's initial comments, he used the phrase "for present and future generations." That is certainly the emphasis that the Alliance of Seniors and its affiliated organizations use. We're very concerned about where this is going and who it might negatively impact on.

Mrs. Witmer: Thank you very much. I would certainly agree with my colleague Ms. Martel, who has very eloquently pointed out the huge powers of the minister under the LHINs. Despite the fact that the government likes to keep telling people that we're now going to have 14 LHIN CEOs who are going to have board chairs, the reality is that these people aren't going to be any more accessible, and at the end of the day, even if some of them might be accessible and would be prepared to listen to somebody, the minister still has absolute control to do whatever he or she would wish. This tries to deflect some of the criticism away from the minister. Everybody is going to be blaming the LHIN's CEO and the LHIN's

board. There's a buffer there now between the public and the minister, and they can say, "Well, that was the LHIN," whereas in reality, we know that it would have been the minister and it would have been the government that made the decision.

I'm surprised that you haven't bought into Bill 36 and you are so strong in your request that the bill would be withdrawn. You actually are that concerned, and you feel that it needs substantial revision. You're happy with the preamble, but you don't support the rest of it.

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Mr. Dular: Thank you very much for your comments. As I said earlier, we very strongly feel that something has been lost in translation. The ideals are laudable, but the substance of the bill raises our hackles. We've been talking about this, ever since it first came to light, among our various affiliated organizations and their representatives and seniors' groups. We're very worried. Please reconsider.

The Vice-Chair: Thank you very much.

Mr. Pinkus: If I may just interject, as you may realize, we represent over 300,000 seniors in this province, which is a considerable number. We feel that this bill will impact negatively on the senior population. That has been expressed to us by our various seniors' organizations. Hopefully, we can allay their fears by having this revised or looked into again.

The Vice-Chair: Thank you very much.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 786

The Vice-Chair: We have with us right now the Canadian Union of Public Employees, Local 786, St. Joseph's hospital, Hamilton. We have the president with us, Mike Tracey. Welcome, Mike.

Mr. Michael Tracey: Thank you very much for the opportunity to speak here today. I am employed as an electrician at St. Joseph's Healthcare in Hamilton, and I've been there since April 1984. In these more recent years, I have been working as full-time president, as you mentioned, of Local 786, CUPE.

If passed, Bill 36 will give the government new and worrisome powers to enable the restructuring of Ontario's public health care system and its social services. Bill 36 declares in its preamble, paragraphs (a) and (b), to "acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve" and, by establishing LHINs, "enable local communities to make decisions about their local health systems."

This bill does not reflect these sentiments, which is what they really are; rather, it transfers control over local community-based health services providers to the minister, cabinet and, subsequently, the LHINs, thereby centralizing, not localizing, control.

The LHIN boundaries are vast and override all municipal, provincial and social boundaries. The LHIN forward boundary for our area stretches across southern

Ontario, from Lowville in Burlington to Turkey Point in Norfolk to Crystal Beach in Fort Erie to Niagara-on-the-Lake. This large area contains over 150 municipalities and communities. But we don't have to worry; the LHIN will engage them all.

The LHINs are required to engage the community in decisions regarding their local health systems. How can communities respond to the LHINs if the definition of "engagement" is left to regulation? Even public access to LHIN meetings is left to regulation. This is going to compound the newer problems of travel times and distances. These vast boundaries actually act as a deterrent to public input.

LHINs are defined as agents of the crown and act on behalf of government and therefore are responsible to and accountable to the provincial government, not the local community.

The bill identifies the powers that the LHINs have and also the powers that the LHINs do not have. It also makes it obviously clear that decisions on integration, specialization, privatization and contracting out, which all refer to restructuring, will be made by the minister and cabinet, and that the LHINs are in place solely to act as a buffer between the public and government. The fact that, at this stage, anyway, it is evident that LHINs are unaccountable to local communities suggests that the following initiatives should be considered: Eliminate the cabinet authority to have in camera LHIN meetings; a provision for full consultation with the community prior to imposing an accountability agreement on a LHIN; and a provision for extensive public consultation on LHIN boundaries and when the status of a LHIN is altered.

The minister will allocate funding to the LHINs "on the terms and conditions that the minister considers appropriate."

The LHINs will develop an integrated health services plan, or IHSP, that is consistent with the provincial strategic plan. The LHINs will then enter into an accountability agreement with the minister. If there is no agreement on the accountability agreement, then the minister can set it unilaterally. The LHINs will then enter into service accountability agreements with all health service providers that receive funding from the LHIN. The LHIN funding formula will expose the health system to purchaser-provider competition or competitive bidding models that were used with the community care access centres' restructuring. That was an experience that had a profound negative impact on health care workers.

The minister has the power to order integrations directly. Specifically, the minister may order not-for-profit health service providers to cease operating, amalgamate or transfer all of their operations; that's in section 28. But for-profit health service providers are exempted from these threats, and we'd like to know why. Obviously, if one wishes for privatization, one must not upset the privateers.

The minister and cabinet have the power to order any public hospital to cease performing any non-clinical service, which is still yet to be defined, and to transfer it

to another organization, meaning government can dictate how any and all non-clinical services are to be provided by hospitals via contracting out or integrated restructuring. The IHSP will open the door to privatization. The transfer of unionized staff from one facility or organization to another will have a devastating impact on the staff and the system as new voting will have to be held to establish which union will represent whom, in what organization.

If St. Joseph's Healthcare Hamilton is ordered to cease and transfer its non-clinical services to another organization, and if my interpretation of this bill is correct, then the health care workers there are facing a very bleak future. At St. Joseph's Healthcare, all of the cafeteria work at all three sites—the Charlton site, the Mountain site and the ambulatory health services site—has been contracted out already to a private organization, Morrison Food Services. Since then, the level of service has diminished significantly. Although we still have our unionized kitchen staff, a chain-link fence literally runs down the centre of the dietary facility and separates them and the Morrison staff.

St. Joseph's Healthcare Hamilton recently completed the construction of a 10-storey tower at the Charlton Avenue site. The unionized cleaning staff at the site were informed that they would not be doing the cleaning work in the tower, as it is now contracted out. The same issues of dietary and cleaning apply to the CAHS site. The cleaning and dietary staffs were transferred and contract workers came in and took over the work. The same will soon apply to the Mountain site, as the employer has signed a P3, public-private partnership, agreement—or should I say it's an alternative financing procurement initiative? It has also been indicated to the unionized staff that the materials management department is to be contracted out.

As representatives of these affected workers, the appropriate avenue of third party process has been initiated. According to the implications of Bill 36, the minister or the LHIN will very soon be able to order the existing dietary and cleaning services to this private contractor who is already on site. If true, the effect is that the third party process will probably be rendered mute and therefore abandoned. All this is if the minister declares this private contractor a health service provider. If the minister does this, does that mean that a restaurant owner can perform cafeteria or kitchen work in a hospital? Does that mean that Molly Maid cleaners can bid to clean and sterilize patient rooms in hospitals? Cutting back on support services is dangerous, as is evidenced by the numerous deaths of patients in Quebec and across Canada caused by hospital-acquired infections.

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The minister called for the centralization of hospital surgeries, suggesting that not all hospitals need to do knee surgeries. The government has also begun to move surgeries out of hospitals and into clinics, an example being the Kensington eye clinic. The creation of new surgical clinics only further fragments the health care

system and promotes more privatization. Most definitely, a better solution would be to create surgical clinics in hospitals, where the infrastructure to support clinics already exists. More importantly, hospitals have the resources to deal with emergencies that might occur during procedures. Medical and surgical procedures must remain in the public domain.

St. Joseph's Healthcare in Hamilton and its entire staff have successfully weathered the health reform storms over the years, from the complete closure of St. Joe's to the drastic budget cuts in more recent years. Labour relations over these years have been at a level of co-operation that has been envied by other organizations. We were a well-oiled machine, but new initiatives dealing with collaborations, amalgamations, accreditations, the Health Services Restructuring Commission and budget cuts have left us as a lean, mean machine, but we are at least cost-effective. Now we will have to enter the arena of competitive bidding and integration that will end in the dismantling of a proven, well-established organization. I'm quite sure now that the situation of contracting out support services at St. Joseph's Healthcare is an indication of impending budget cuts being prepared for, without consultation, in order to maintain a balanced budget.

Unfortunately, the LHIN reform does not deal directly with the real culprits of rising health care costs, which are the trans-national corporations and their atrocious pricing of drugs and medical equipment, which leaves health care workers and the patients they care for to bear the burden of those costs.

Because the IHSP integration will remove jobs and services from the public domain and local communities, the following initiatives should be considered: Provide in the bill that nothing in the legislation authorizes cabinet, the minister or the LHINs to override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements; and remove from the bill the power of the LHINs, the minister and the cabinet to transform the health care system unilaterally.

Bill 36 will give the LHINs, minister and cabinet the legal authority to privatize large parts of our publicly delivered health care system. The LHINs will purchase services and hospitals, homes, community agencies and for-profit corporations will attempt to provide them. This is where a competitive bidding model becomes a very real threat to the providers of health care in the community. The LHINs would have the power to allocate funding or services to hospitals that underbid for knee and hip replacements, cataract surgeries etc. and, depending on the location of the successful bidder, patients would be required to travel even further to access health care services. The reality of an unsuccessful bid would be the layoff of health care workers in order to achieve and maintain a balanced budget according to the funding that's allocated. I would therefore suggest adoption of the following: that competitive-bidding models should be specifically excluded in this legislation, considering the negative impact it has already had on social services and CCACs.

The change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act to many of the potential changes in employment that could result.

The Chair: Can you conclude, sir, please?

Mr. Tracey: Okay. Most of my suggested initiatives and recommendations, which you have in detail in your written submission, are the same, if not similar, in wording to CUPE. Believe me when I say that I had thought of them before they did, but I used their more concise wording.

The minister states that the LHINs would be required to engage the community on an ongoing basis to develop an IHSP that would include a vision. The minister also states that it must be consistent with the provincial strategic plan. When a vision appears to a person—and history tells us that many individuals, ranging from the geniuses of this world to the lunatics, have been inspired by such vision—that person wishing to realize that vision must share that vision with those entities who can enable such a vision. The entities are identified in the preamble of the bill: "The people of Ontario and their government." When will the people of Ontario get to see this vision? After it's totally completed? Thank you very much.

The Chair: Thank you for your presentation, sir.

We will break for lunch. We'll be back here at 1 o'clock. I thank all of you.

The committee recessed from 1207 to 1305.

COUNCIL OF ACADEMIC HOSPITALS OF ONTARIO

The Chair: Good afternoon. We can start our first presentation for the afternoon. It's from the Council of Academic Hospitals of Ontario. We have Dr. Jack Kitts and Mary Catherine Lindberg. You can start your presentation whenever you're ready. There is a maximum time of 15 minutes allowed.

Dr. Jack Kitts: Thank you very much. As introduced, my name is Jack Kitts. I am the president and CEO of the Ottawa Hospital, but I'm here today in my capacity as chair of the Council of Academic Hospitals of Ontario, which I'll refer to as CAHO. Joining me, as introduced, is Mary Catherine Lindberg, who is our executive director at CAHO.

On behalf of all of the members at CAHO, I want to thank you for the opportunity to table our comments and observations with respect to Bill 36. The Council of Academic Hospitals of Ontario is a not-for-profit organization. We represent 22 academic hospitals in Ontario with annual operating budgets ranging from \$25 million to \$1 billion per annum. This investment is close to \$6 billion and accounts for 45% of the resources spent on hospitals in Ontario.

Academic hospitals are large and complex organizations that provide a broad and complex set of services.

Our mission or our mandate is really threefold: First, we provide care for the most complex patients; second, we train future physicians and all other types of health care providers; and third, we provide a focal point for world-class research that contributes to improved patient care, new innovations and best practices.

We also serve as an important economic driver in society, creating new knowledge, new innovations and new jobs. These economic spinoffs contribute to Ontario's quality of life, our international competitiveness and economic prosperity. We also provide leadership to assist in the transformation and sustainability of our health care system. Collectively, these roles result in a complex set of current local, provincial and national working relationships with other hospitals, other health service providers, universities and colleges, specialized provincial health networks and a variety of government bodies that contribute to the various aspects of the academic mandate.

Bill 36 is an important and defining piece of legislation. The impact of the bill on the role and reach of the academic hospitals will be significant and requires careful consideration. I would ask you to consider the following:

First, Ontario teaching hospitals and their hospital-based research institutes conduct over 70% of the health research in the province. This represents 40% to 50% of Ontario's entire research enterprise. The money spent on hospital-based research provides a major impetus that leads to better patient care, improved population health and greater efficiencies. Much of the research relating to health care will inform the strategies and decisions made by our LHIN boards.

Second, academic hospitals are intimately involved in educating the full range of future health professionals, in collaboration with many different academic institutions. Ensuring the right number and mix of appropriately prepared health care providers will be a key challenge shared by all of us. If LHINs are to become fully engaged in meeting this challenge, Bill 36 will need to acknowledge their role.

Third, based on the current LHIN boundaries, the 22 academic hospitals in this province are located in seven of the 14 LHINs; 40% of them are located within a single LHIN in Toronto. Significant movement of patients across LHIN borders will be a reality. If the mandate of the LHINs is to be realized, all 14 LHINs will be significantly dependent on academic hospitals to plan services and achieve a continuum of care for the population they serve. Given these facts alone, it is clear that Bill 36 must acknowledge the importance of research, innovation and teaching in improving the health of Ontarians.

Given the time allotted for the presentation today, we will focus on three key areas of concern with respect to the bill: first, omissions from the purpose of the bill and LHIN objects; second, the power of the minister to require hospital foundations to provide financial reports to LHINs; and third, the implications arising from the

minister's ability to assign contractual rights and obligations to LHINs.

Details with respect to the amendments we are proposing will be found appended to our brief.

Issue 1: We believe that the purpose statement described in section 1 is under-inclusive and that the list of objects included in section 5 is incomplete. The purpose statement in Bill 36 is missing two critical points: first, it lacks reference to the need to improve the health of Ontarians through better access to high-quality health services; and second, it lacks reference to the need to ensure coordination of health services not only at the local health system level but across local health systems and across the province.

CAHO recommends that section 1 be amended to include reference to both of these points.

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Another key shortcoming of the bill relates to the lack of reference made to education, research and knowledge transfer in the list of LHIN objects of the bill. Each of these activities is vital for ensuring quality, efficiency, effectiveness and sustainability across the full continuum of the health care system.

As already mentioned, we believe that Bill 36 must acknowledge the importance of research and innovation for improving the health of Ontarians and give LHINs a role with respect to health research, innovation and best practices, and quality of care. We have developed specific amendments to section 5 to address this.

Finally, with respect to section 5, we propose that a new clause be added, referencing the need for LHINs to support the training of future health care professionals, as well as health human resources planning and education.

Issue 2: With respect to the power of the minister to require hospital foundations to provide financial reports to LHINs, we believe the amendment proposed to the Public Hospitals Act in section 50 of the bill is unnecessary and inconsistent with other provisions in the bill. We support the concerns raised by the Ontario Hospital Association in its brief yesterday regarding the proposed amendment to the Public Hospitals Act that could result in hospital foundations having to provide financial records and reports to the LHINs.

Because foundations are not within LHIN jurisdiction under Bill 36, and because Bill 36 already contains a section relating to LHINs' ability to require reports from entities that are not within their jurisdiction, we ask that consideration be given to deleting the proposed amendment.

Finally, we are concerned about the broad scope of the minister's power to assign contracts under subsection 19(3). This subsection is overly inclusive. The broad nature of the assignment of contract provisions in the bill has the potential to seriously jeopardize and undermine the progress that has been made in negotiating key contracts, particularly with academic physicians, in terms of alternate funding plans, alternate funding arrangements, and hospital on-call committee agreements.

Currently, these agreements involve the minister, health service providers and third parties, and are derived

from centrally bargained and negotiated agreements. Accordingly, we believe that the minister should continue to administer these on a provincial basis. At a minimum, the agreements should be administered by an entity with a provincial mandate relating to research, education and, where appropriate, physician matters, in addition to funding responsibility concerning physicians, hospitals and other health service providers.

Because of the importance of the alternate funding arrangements and AFP initiatives, and the complexity of the issues involved in agreements relating to alternate funding arrangements, including issues that transcend LHIN boundaries and are of provincial scope and concern, CAHO recommends that subsection 19(3) be amended to require the minister to make a regulation where there is an assignment of an agreement which includes an entity that is not a health service provider. Appended to our written brief is specific wording for revising this section accordingly.

In conclusion, I want to emphasize CAHO's strong support for local health integration networks in Ontario. We must strengthen planning, coordination and integration of health services at the local level to improve access and timeliness of patient care. In doing so, however, we need to make sure that the legislation will facilitate effective working relationships between academic hospitals and LHINs, and acknowledge collective roles and responsibilities with respect to clinical care, teaching requirements and the promotion of research and best practices.

Thank you for this opportunity.

The Chair: Thank you. There are about three minutes. I'll start with Mr. Arnott, please.

Mr. Arnott: Thank you very much for your presentation. I want to ask you a question about the second issue that you raised in the course of your presentation. You said, "With respect to the power of the minister to require hospital foundations to provide financial reports to the LHINs, we believe the amendment proposed to the Public Hospitals Act ... is unnecessary and inconsistent with other provisions in the bill." Could you tell us again why you feel that way and why you suppose the government included that provision in Bill 36?

Dr. Kitts: I'm not sure why the provision was included, because under the Public Hospitals Act there is that provision. The concern, I guess, is that anything that might be detrimental to fundraising activities for hospitals, and particularly for teaching hospitals, where research is funded almost exclusively by fundraising, any cutback in fundraising and research dollars will negatively impact our future. So that's why I think we're particularly concerned about that.

Mr. Arnott: But it certainly raises the spectre, I guess you'd say, of the Minister of Health sticking his nose into the private business of hospital foundations. One would question, why is that happening? Certainly, you might conclude that he's trying to get his hands on some of this money. This is the concern that we're hearing from a number of people. I would hope that that's not the case,

but I think the government has to respond in a way that reassures people that that is not what's planned.

Dr. Kitts: I don't know the reasons, but my concern and CAHO's concern is anything that might negatively impact on our ability to fundraise for research will negatively impact on the future of our health system.

The Chair: Thank you. Ms. Martel, please.

Ms. Martel: Thank you for your presentation today. I wanted to focus on how you might see your participation in the planning that goes on being assured by the LHINs. You were right, there's not a reference now, despite the very important role that's played by academic health centres. So what suggestions do you have? I appreciate the concerns you've related, but I'm more interested in some of the concerns that you might have about how you ensure your voice, your role, is heard and played in this—

Dr. Kitts: That's a very good question. I can look at the health system from my perspective both as a physician and as chief of an academic department in an academic hospital and now, more recently, as a CEO. There's no question, whether it's an academic hospital or any hospital, that the debate between medical leadership and administration and boards, when resources are short, turns to, "Well, if we're a hospital, we should be focusing more resources on patient care, because that's what hospitals do, and let the universities handle the education and the research institutes worry about the research." But the fact of the matter is, in an academic health science centre those three are completely intertwined and must be. So we would like to have provisions in there to let the leadership of the LHINs—the boards and the CEOs—know that the academic mandate is absolutely essential, not only for current health care but particularly for our children and our grandchildren for years to come. We would like to see explicitly stated that while LHINs is health care, the academic mission must be protected.

The Chair: Thank you. Mr. Levac.

Mr. Dave Levac (Brant): First of all, thanks very much for your presentation and well-thought-out concerns and recommendations. You, along with a few other deputations, have indicated a concern about the foundations issue. We've heard it quite clearly. Quite contrary to my colleague across the way, there was never a mention of anyone getting their greedy little hands on the money, and I don't want to have you characterized as asking that question either. It's unfortunate it was characterized that way. I would suggest that those concerns that have been brought up are definitely heard and we'll be working on those.

The second question that I do have for you, though, is a relationship between hospitals, academic hospitals and the LHINs. In my LHIN, for example, the 14 hospitals have gotten together and they're going to coordinate all of their IT so that the communications process—what are the academic hospitals doing or are they doing something that would help us benefit the LHINs and the patient at the end of the road?

Dr. Kitts: In many cases, the most complex patients end up on the continuum at an academic hospital because

that's where the tertiary care is concentrated, the latest technology and equipment. What the academic hospitals offer as part of the LHIN is that we work with—the 14 hospitals in your area plus the community partners sit down and plan the clinical services distribution, who is going to do what. That has never been done before. Everybody has continued to plan in silos. So the academic hospitals can then reach out to the partners in the LHIN and say the continuum is this: Maybe a small community hospital does this primary care, it moves on to a larger, more regional hospital and then ultimately to the academic centre. So basically we just want to work in partnership with them.

What the other hospitals don't have, though, is a mandate to educate future health professionals and do research. That is really the key to a sustainable system. We'd like to have that recognized, that we'll all do that together. Studies have shown that where doctors train, they often stay. I think it would be remiss of us if we didn't send them out into the other partners in the LHIN for their educational experiences, and that's why I'd like to have it in the LHIN that that's a protected—

Mr. Levac: A great rationale.

The Chair: Thank you very much for your presentation.

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ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair: We'll get the next presentation, from the Ontario College of Family Physicians. It's Dr. Levitt and Jan Kasperski. Good afternoon. You can start any time you are ready, Doctor.

Dr. Cheryl Levitt: Hello, everyone. My name is Cheryl Levitt, and I'm president of the Ontario College of Family Physicians, the OCFP. With me today is our executive director and CEO, Jan Kasperski. Thanks for the opportunity to present the Ontario College of Family Physicians' reaction and concerns regarding the LHIN legislation to the standing committee on social policy.

The OCFP is the voice of family medicine in Ontario and represents more than 7,300 family physicians. Our purpose is to build and maintain the highest standards of practice, maintain competence through continuing professional development of our members and advocate for improved access to high-quality family medicine services for all residents of Ontario. We live in communities throughout the province and provide family medicine care for all Ontarians. By listening to the voices of family doctors, you will hear the concerns of all our citizens about our health care. Moreover, we feel that family doctors are the canaries in the health care mineshaft. We are able to inform you in an early, expert and dispassionate manner about what works in the system and what doesn't.

Family medicine is the cornerstone of the health care system. The evidence is clear: An enhanced primary care system in which every person has a family physician will

save Ontario millions of dollars; provide more equitable care for socially deprived populations, especially children; lower the all-cause mortality, all-cause premature mortality and cause-specific mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease and heart disease, and numerous other maladies; and contribute to Ontario communities, small and large, as facilitators of social and economic well-being and growth. Yet more than 1.4 million Ontarians do not have access to a family doctor.

I wish to state at the outset that while we participate in Ontario society as family physicians, and specifically are intervening here, we always do so not primarily to serve our own interests as family physicians, but rather to serve the public interest as a whole. Our profession is unparalleled in its dispassionate dedication to the broader public interest. Even when we might be perceived as speaking for ourselves, we do so because of the central role our discipline plays in our patients'—that is, all Ontarians'—lives. We strongly believe that in order to continue to do so, we must ensure the strength, numbers, sustainability and viability of our discipline.

The OCFP is concerned about the new LHIN legislation. We believe that regionalization, if it is to be undertaken, should be occurring because it's a mechanism that will improve the state of health care for all Ontarians. We are open to this being the case, but are not yet convinced that this is so. In any case, most fundamentally, we believe this should be attained through improved family medicine-based primary care services and whole-population access to family physicians. Unless this is made an explicit goal of the legislation, we believe the exercise may simply be one that deflects discussion and action from the central concern of most Ontarians about their health care, namely, continuous and proper access to family physicians.

Please do not mistake our intervention as an effort on the part of family physicians in Ontario to protect or further our own interests as a group or to perpetuate a perceived status quo. Family physicians are not frightened of social change. On the contrary, we are advocates of constructive, evidence-based efforts to do away with impediments to the effective provision of optimal medical care to all Ontarians and to put in place major innovations that will ensure this critical goal. Our discussion paper, *Starting with Primary Care: Patient/Family Centred Organizational Transformation*, based on our consultations with health care leaders throughout the province, documents the needed changes that we envisage. However, we feel that this must not be undertaken on the basis of this season's ideology or change for change's sake. It must rather be undertaken on a foundation of evidence-based approaches and open, transparent and rational considerations of whether or not what's being proposed meets the test of being in the public interest.

We wish to make the following recommendations with respect to the LHIN legislation:

There are many competing interests for resources in health care. If, as we believe the evidence shows, family

medicine and family medicine-based primary care are the single most important investments that will guarantee a healthier society, then this should be made explicit in the legislation.

The preamble and part III of the bill should explicitly state and ensure that family medicine and family medicine-based primary care is a central priority, including in the provincial strategic plan and in the integrated health services plan of each LHIN, as key to ensuring better access to high-quality, cost-effective health services in Ontario.

Bill 36 calls for the development of a provincial strategic plan and the engagement of the community in the development of an integrated health services plan for each LHIN. Family doctors need to be involved in the development of the PSP and seen as key members of the community in the development of each IHSP.

Subsection 16(1) needs to provide the definition of the term “community,” and community-based family doctors need to be included in that consultation process.

We also support the amendment to the bill as proposed by the Ontario Hospital Association in regard to part II, section 5, “objects”; and part V, subsections 25(2) and 28(2).

The OCFP actively participated in a multi-stakeholder consultation process led by our colleagues at the Ontario Hospital Association to develop the principles which should underpin the functioning of the LHINs. The OCFP used this work to demonstrate how the LHIN principles could drive decision-making in Ontario. Our discussion paper, *Local Health Integration Networks: A Means Not an End*, provides an overview of key recommendations that we hope would influence the spirit of the legislation and any policy decisions that flow from the legislation. We would like to submit the paper to you as a backgrounder to our input on the legislation.

Subsection 16(2) calls for the health professionals advisory committee. The OCFP does not believe that this broad-based group can or will adequately ensure that family doctors are properly consulted. LHINs will fundamentally change the way many health care services are delivered in this province. Physician involvement in general and family physician involvement in particular is vital in the management and organization of local health care. The Ontario Medical Association has proposed that each LHIN should support the development of a physician advisory body composed of specialists from the hospital sector and physicians from the community representing doctors who deliver care in family practices, long-term care, home care and public health. The OCFP supports the development of a physician advisory committee.

The LHIN legislation or regulations must ensure that physicians are properly consulted and formally included in LHIN structures through a physician advisory committee.

In addition, the LHIN legislation or regulations must ensure that family physicians are properly consulted and included in LHIN structures through a family medicine

advisory committee, as proposed in our report, *Linking Family Physicians with Local Health Integration Networks (LHINs)* in Ontario, which we have provided here.

The FMAC is specifically aimed at addressing the issues facing family medicine and improving the interface between primary care and the rest of the system.

The province is investing significantly in increasing the number of family doctors and in developing better access to family medicine through the support of group practices, including family health teams. Our research indicates that the LHINs must invest in supportive organizational structures to hear the voice of family physicians and to foster integration at the point of care in family practices and throughout the system. Family physicians need the same structure to support them to identify patient care issues, to problem-solve and to undertake quality improvement activities.

In our report, *Linking Family Physicians with LHINs*, which we submit, we propose a 10-point approach to the structure and function of the family medicine advisory committee, FMAC.

The LHIN legislation is virtually silent on improving the quality of care rather than cost saving and cost-cutting. In reviewing the development of regional health authorities across Canada, we are acutely aware of the fact that the drive for savings in the system led to the consolidation of services in larger centres and closure of small hospitals. Inequitable distribution of resources, travelling long distances for care and lack of a holistic approach to care—i.e., care that treats people as a series of body parts to be distributed throughout a city—is not, in our minds, a quality approach to system planning. The legislation should establish parameters for protection of small communities through fire walls.

The LHIN legislation, through the provincial strategic plan and the IHSPs, should protect the erosion of resources from small communities by establishing fire walls.

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The LHINs cannot only be about building regional structures and devolving responsibility. They must be about continuously improving quality, making sure that we get the very best value for money and using the new regional structure to build a truly better service. Section 1, the purpose of the act, needs to be changed to reference access to high-quality health service, coordinated locally and across the province. The legislation should require that the LHIN demonstrate improved quality of care for Ontarians. The IHSPs should include detailed plans for continuous quality improvement and ongoing evaluation.

The legislation is also silent on the role of the LHINs in protecting, promoting and supporting the education and continued professional development of health care professionals, clinical research, and health services research and evaluation. Quality practices in health care do not occur in a vacuum. Universities and colleges preparing future health care providers must plan in partner-

ship with their regions. The LHINs must ensure that providers are encouraged to practise high-quality care and to continually maintain and enhance their competence. Clinical research is needed to develop new knowledge and evidence, and the legislation must ensure LHINs undertake evaluative research.

The legislation should stipulate the role of LHINs in protecting, promoting and supporting education, continuing professional development of practitioners, clinical research, and health systems research and evaluation. Their link with the colleges and universities should be made explicit in the legislation. Amendments to sections 25 and 28, as per OHA's recommendations, should be added to the bill.

In closing, we would like to thank you for this opportunity to present our views. We would welcome any opportunity to work with you on these points as this important legislation is carried forward.

The Chair: Thank you. You've used the 15 minutes. There is no time for questioning, but we thank you for your presentation.

CHIEFS OF ONTARIO

The Chair: The next presentation is from the Chiefs of Ontario. We have Angus Toulouse, Ontario regional chief, Chiefs of Ontario; Randall Phillips; and Paul Capon. Meegwetw to you, gentlemen. Please proceed whenever you are ready. It's your floor, sir.

Regional Chief Angus Toulouse: First of all, I'd like to acknowledge the Mississaugas of New Credit, whose territory we are sitting in today. I am the Ontario regional chief, elected by the 134 First Nations in Ontario. The status Indian population of these First Nations is the largest of any province in Canada.

In June 2005, Ontario shared its newly developed aboriginal policy titled Ontario's New Approach to Aboriginal Affairs. To quote from the document, "Ontario recognizes that First Nations have existing governments and is committed to dealing with First Nations' governments in a co-operative and respectful manner that is consistent with their status as governments.... Aboriginal peoples will have greater involvement in matters that directly affect their communities, including where applicable in programs and service delivery."

In relation to First Nations health services and programs, Ontario's new approach has yet to be implemented.

The already established LHIN boards and the LHIN legislation will have significant impacts on First Nation health services. The First Nation task force identified seven areas that raised concerns and issues.

Number one, governance and accountability: The establishment of a forum on financial services would require the involvement of the federal crown, which has the primary fiduciary relationship with First Nations, particularly in the health field. Another possibility would be the implementation of a bilateral intergovernmental forum with First Nation leadership for the purpose of

establishing a new organizational entity or institution dedicated to First Nations health in Ontario. Such an entity could be designed to reflect the government-to-government relationship and serve to ensure transparency, accountability, and efficient use of federal and provincial funds in meeting the health and healing needs of First Nation citizens, regardless of residency.

The new health organization could develop joint First Nation ministerial protocols, standards, research, health criteria, and could conduct performance management and evaluation of the LHINs, as well as ancillary and related services of the ministry and the Aboriginal Healing and Wellness secretariat.

Health system planning and evaluation: For the LHINs to be accountable to First Nation citizens on and off reserve, First Nations are concerned that LHINs may undermine our jurisdiction. First Nations have the right to decide our own health criteria, and we need to maintain ownership of this information. This may result in a First Nation performance management and evaluation process being established to ensure that our citizens' health needs are met according to the treaty and fiduciary obligations of the Crown.

Service delivery coordination and integration: Service delivery on and off reserve must be maintained and enhanced for the protection of First Nation programs and planning within mainstream institutions and in First Nation communities. Services and programs must be developed by First Nation governments for citizens both on and off reserve, which include planning, implementation and evaluation. This could be accomplished through a First Nations health organization with authority to make recommendations and implement change at the provincial and individual local LHIN levels.

Human resources and staffing: There is a lack of capacity in First Nation communities, both on and off reserve, in terms of professional support. Health staff in the mainstream health care systems are often not equipped with the proper skills and knowledge to deal with First Nation communities, particularly cultural knowledge. To ensure First Nation health needs are understood and met, there must be cultural training of provincial and LHIN staff, including provisions for translators. This would also involve First Nation leadership being involved in the selection of staff and reviewing qualifications before a person is sent to a First Nation community, particularly a remote northern community.

Northern issues: Northern First Nation communities have unique circumstances that must be considered. Even basic services are a priority for the North. To ensure these circumstances are considered, the provincial government and the LHINs must factor in remoteness. If these communities are ignored, the service gap in the north will only get worse. The significance of these issues calls for a government-to-government relationship.

Roles of Health Canada: The task force has advised that Health Canada must maintain its fiduciary responsibility and that the federal government must be accountable to First Nations in the provision of services, regardless of collaboration with the provincial govern-

ment. The best option is to use the intergovernmental process to bring the federal government to the table to negotiate with First Nations, the province and the LHINs. This must be a flexible, collaborative and coordinated effort.

Community engagement: There must be engagement of individual First Nation communities and citizens residing on and off reserve, given the fact that each First Nation's rights and interests are unique. Joint decision-making processes must be developed and implemented to ensure communications continue on an ongoing basis.

The legislation affects First Nation rights and interests. The LHINs boards have a direct impact on the 134 First Nations communities across Ontario. Despite the lack of appropriate notification, First Nations participated with the minister and ministry in good faith to attempt to determine the impact of the LHINs. First Nation participation in the process did not receive the respect it is entitled to: the special relationship First Nations have with the crown. The LHINs legislation was pushed forward despite First Nation efforts. The minister had not yet responded formally to the final recommendations and report of the First Nations task force. Despite First Nations' efforts, our legal rights and interests have not been accommodated. This is not consistent with the honour of the crown. Based on this, legislative exemption is what First Nations are seeking.

The draft legislation should be delayed to permit a full government-to-government dialogue with First Nations. In that context, First Nation representatives would be prepared to discuss and develop positive alternatives and options. It should be possible to develop a model that respects First Nation rights and interests, as well as the provincial imperative with financial resources and administrative efficiency.

This is pretty much the end of the presentation. As noted, a more formal written presentation will be submitted in short order. If there is any time, I would be glad to answer any of the questions you may have.

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The Chair: We've got plenty of time. A couple of minutes, Ms. Martel.

Ms. Martel: Meegwetich. Welcome, Chiefs and support staff. I'm not sure of your appropriate titles.

The top of the presentation, which you didn't read, clearly outlines the lack of real consultation that went on with First Nations with respect to this bill. This is an issue that we have heard before, in other communities that we have visited, but I'm glad that you put it in writing to clearly show what your expectations were and how your expectations were not met—not just your expectations, but your treaty and other rights with respect to consultation have not been met, as well.

At the end of the presentation, then, you make it very clear that you are seeking a legislative exemption. Are we going to receive the actual copy of that? Do you have that with you? Because I don't think it's attached to my copy of the presentation. Would this be a non-derogation clause essentially, or something else?

Chief Randall Phillips: Perhaps, if I could make that distinction, we are looking at an exemption with respect to the complexity of our services in the service delivery process right now. That's what we're looking at in terms of that type of thing. I know that the minister had talked about those types of things.

But with regard to the non-derogation clause, we are talking about two separate issues: One, the non-derogation clause firmly recognizes our aboriginal treaty rights and that whatever is in that legislation must have a mechanism to deal with that. That's the distinction that we make in there. With respect to the exemption, our concern, of course, is the governance ability of LHINs to override any of the decisions that we make or that will impact on our current service delivery and our jurisdiction within that whole area of health. I hope that helps.

Ms. Martel: Yes, it does, but can I be clear? You're looking for two things then, not one: You want a legislative exemption, but you also want a non-derogation clause?

Chief Phillips: We've taken a traditional stance, not only in Ontario but across Canada, that with respect to any legislation, a non-derogation clause be included in there. That provides the federal and the provincial governments with a mechanism to deal with those treaty and aboriginal rights that are addressed within legislation. So it is a non-derogation clause. We've asked for that consistently with regard to any legislation; this one is no different.

The Chair: Mr. Levac.

Mr. Levac: Meegwetich, Angus. I have a question basically about the end story. The end story, if I'm not mistaken, is to better the health care system for the First Nations people. Is there any value that you see in your evaluation of the LHINs as they presently stand that would provide some of that assistance, given some of the circumstances that need to be overcome, obviously? And I would suggest that, respectfully, we have to get through that, and then at the end story, which is the health care provision, are there ways in which LHINs can show, after your evaluation, that there would be some good end story to this issue?

Regional Chief Toulouse: Chief Phillips will address that again, as chair of our task force.

Mr. Levac: Just before you do that, I understand you've met and will be meeting shortly with the minister to outline some of the specific concerns that you have regarding the process?

Chief Phillips: Yes, to both of those.

Your question is very good. Unfortunately, I'm not in a position to see exactly how the LHINs will respond to our issues and concerns, so this notion of whether or not they're going to actually advance or address our health concerns—I just want to make it clear to committee members that within this whole Ontario health transition, First Nations are included in that, so if the goal here is to improve health status, then we need to focus on First Nations communities and there needs to be some specific direction either given to the LHINs or a separate process

that deals with these issues. That's why we're looking at this not only as a separate process—enhance and confirm that we're still following along this notion of treaty and aboriginal rights—but the minister has also mentioned the fact that he is looking at, the best way to say it, implementation at the ground level.

Those were the concerns that we addressed right from the get-go when we found out about LHINs, so there seems to be some movement towards trying to at least accept that notion and put that into some kind of legislative framework or comment or whatever else.

I don't know whether these processes will work and enhance and direct and address our health concerns, but we're certainly hopeful that once we get down to that engagement level at the community level it's going to move towards that. That is our goal, of course: to enhance our own health services.

Mr. Arnott: It was approximately seven months ago that the government released Ontario's New Approach to Aboriginal Affairs, June 2005, and it was only a few months later that the government made an internal decision to move forward with health services restructuring, regionalization of health services, creating these new authorities that they call local health integration networks. Did the Minister of Health not know about the new approach to aboriginal affairs? How would you account for the fact that the government completely ignored that policy or completely overlooked their obligation to consult with First Nations? How can you account for that?

Regional Chief Toulouse: It's unfortunate that not only this government but many governments overlook their duty to consult First Nations. We are constitutionally recognized people. It's unfortunate that a lot of times this is what happens when there's a new announcement. Even a lot of the new approach is done in isolation, with not much consultation. But we did speak to the minister, and I think there's some willingness to recognize that we are nations and we need to have a government-to-government relationship and we need to have discussions in building a relationship along those same lines. That has certainly been communicated to the Premier and to various other ministers within this particular cabinet that that's what we're talking about when we're talking about a new approach to dealing with First Nations people and communities in Ontario. That's something that we want to continue to build upon. I agree that there wasn't much consultation when that was drafted, where it's understood as to what's meant by "new approach" and a consultation with First Nations leadership and communities.

Chief Phillips: If I could just add to that, prior to this whole exercise, the First Nations were involved with a first ministers meeting, and one of the issues they talked about was health. The Minister of Health for Ontario led that process, so I'm assuming that he would know of the requirement to deal with First Nations. I'll just leave it at that.

The Chair: Thank you, gentlemen, for your presentation.

KRISTY DAVIDSON
DOUG ALLAN

The Chair: The next presentation is from Kristy Davidson. There will be 15 minutes for your presentation, and if there is any time left, there might be questions or statements from the members. Just start whenever you're ready.

Ms. Kristy Davidson: Good afternoon, everyone. My name is Kristy Davidson. I live and work in Toronto. Having reviewed Bill 36, I have a number of concerns that I want to bring to your attention. I am particularly concerned about how local the structure truly is. I'm also very worried that what Bill 36 creates is actually not better for Ontarians in terms of the health care services we have and how we access them. I also am really concerned that it doesn't truly integrate services. Also, around the issue of networks, I believe they may actually not be true networks, that they may be some false networks, and I'm going into that specifically now.

Getting back to my point about how they may not be truly local, I'm concerned about representation and the fact that the boards are appointed and that the minister has the ability to pass the minister's power on to those boards. The boards are driven by the minister's strategic plan, which members of the public also don't have access to. I believe, all in all, that removes the responsibility, the accountability, from the elected MPPs. I also don't see in here any representation of workers, of equity groups and of communities as they presently exist, and that causes me great concern. My answer to those concerns is that the boards, if we are going to have them, should be elected, like our school trustees are.

Around the issue of community involvement, I don't see any minimum level of community engagement or access to meetings for members of the public, and I believe that a lack of local input into services will create instability locally. My answer to this is that we have legislated protection of democratic and meaningful community input.

1350

My last point on the issue of whether or not LHINs are actually local is around the fact that I don't believe LHINs reflect the way that communities are presently organized. If we look at municipalities and the provinces and the federal ridings, they're getting their boundaries together, but the LHINs come along and create an additional boundary. I'll give you a personal example. I live in Toronto. I access one hospital for specialist services. My partner accesses another. Those two hospitals, in the plan as I understand it, will be in two different LHINs. Now, that's not to say that I need to have my services in one LHIN, but my point is that the LHINs maintain that they reflect the referral patterns and the existing patterns of services, but I really don't think they do in that they don't reflect the existing boundaries. For example, for Toronto, one city, to have five LHINs, I don't see how that is a reflection of local structures.

Moving on to the next part of the acronym—getting off of "local" and looking at "health"—I'm concerned

about the existing health care services and that this is simply an attempt to spread the strategy of competitive bidding. I'm on the executive board of a local social service provider in a community, and I see what competitive bidding does to the services that this agency is able to provide. They spend more time and money worrying about what to apply for and how to apply for it and who to hire to do the application than they do on planning the services that are needed and delivering those services. Section 33 specifically calls for privatization of non-clinical services, and that is of deep concern to me. Public health care is what we have paid our taxes for and what we have believed in the principles of the Canada Health Act, and they're what we should continue to support. So my answer to this concern is that we include protection of all existing health care systems in the legislation and specifically that we exclude competitive bidding as well.

Moving on to the next part of the acronym, under "integration," I don't see how it is actually true integration. It seems to be a selective integration. There are critical parts of the system that are not aligned: no major providers, like family doctors, dentists, optometrists, labs, provincial drug programs. Again, my answer for this would be true integration of all health care providers, and when and if other services are to be integrated into the LHINs, we need to have further consultation if we're looking at having public health and ambulance become part of LHIN structures.

I really do believe that integration, as I see it here, is a misnomer. The networks cover large areas, and yet they sharpen regional inequalities. I'd like to give another personal example. I'm originally from Sault Ste. Marie, and I have a grandparent there. To get her surgery she had to come to Toronto and stay for four months to recover. The initial guess at how long the recovery would take was two months; it actually took her twice as long, because she was outside her regular circle of family and friends. Depression sets in and it increases the time it takes to recover. These costs are not factored in here, the costs of someone to travel through a LHIN to get to a service, from Toronto to Parry Sound or vice versa, or the travel for families who then have to go to a completely other part of their region to support a relative who has had to travel there to get the surgery. These are not factored in. Again, my answer to that is that the LHINs need to reflect the existing boundaries.

My last point, about the network issue of LHINs, is that the word "network" suggests strength, stability, togetherness, but I do believe that the networks as suggested here actually interrupt and separate the existing patterns of service delivery. The services have developed over time in response to community needs, and yet the powers given to LHINs can ignore all of that work and all of that history in communities. Boards can order closures for not-for-profits. They can merge services from provider to provider. They can order transfers of property from provider to provider. These services that have developed over time based on community need can

completely disappear. We come back to the issue of, who do you go to with your concerns about that: a board that you haven't elected and that you have no connection to? My answer to that is that we add protections into the legislation for existing local services, including and particularly in the not-for-profit area.

I have one sheet, and I think copies have been distributed. It is basically the summary of the points I have made here today. I don't believe that LHINs really live up to their name. I don't believe that they are truly local or that they are truly good for public health, and I am concerned that, at best, this attempt to integrate health care is premature and, at worst, it's harmful. It's harmful to me as a resident, it's harmful to workers, and it's harmful to our whole public health care system in Ontario.

I urge the government to act on the suggestions that have been made here, and I thank you very much for your time.

The Chair: Thank you for your presentation. We have a minute and a half each.

Mr. Khalil Ramal (London-Fanshawe): I listened carefully to all the points you mentioned. Hopefully, after we implement the LHINs, when the law passes, you'll change your belief and you will be convinced that LHINs are a good invention for the health care of Ontario.

First, you mentioned "local." I don't understand how you don't see that it's more local than the present situation with health care since we have right now, almost, one LHIN covering the whole province, and we have 14 with this bill. It will be divided into many different sections to help the smaller communities have better input, a better say, in health care delivery. The minister yesterday, in the Timmins Daily Press, mentioned that with the implementation of LHINs, the smaller communities will have more to say, especially when it comes to health care decision-making.

About the service: You mentioned your partner goes to one hospital and you go to a second hospital. Implementation of LHINs is not going to change the service. You'll go wherever you want, you'll choose whatever hospital you want to be treated in, and it's not going to affect you at all. The LHINs can only work on the limitation of the administration level and also work to consolidate the service. It's not going to affect the people or the clients if they decide to go to this hospital or another hospital.

The present situation is not going to—you said the LHIN has more authority now than before to close and to open. The minister will still have the same authority over the LHIN as in the past and it will continue in the future. Also, he said in his opening remarks, when he opened this session for the committee, that he is against any hospital closures and he is working toward maintaining health care in the public domain.

Ms. Davidson: In response to your comments about the issue of whether they're local or not, my point is really about local access and accountability, and if your local connection to the LHINs is a board that you have

had no input into how they operate and you have no future chance of that, whereas with the existing system now, as you described it, there is that connection through your MPP and there is certainly a local connection. There's my example in Sault Ste. Marie, and I've seen how the health care system has developed there with the group health centre and then the addition of the women's health centre and the addition of a west end health centre. That all came from community input and from direct community pressure. There is no connection here. I don't see the connection here—

Mr. Ramal: It's perfectly clear about the community involvement.

Ms. Davidson: —between the community and a board that is not elected and that can have the minister's duties passed on to it. So the one elected person who maybe would be there can pass on their responsibilities to the board.

Mr. Doug Allan: If I could just add one point, I think part of the concern that many presenters have raised is that the powers that have been given to cabinet, to the minister and to their agents, the LHINs, are so extensive that the vitality of existing boards is seriously threatened. The way community health care has been preserved and expanded when other parties and other governments have been in power has been because communities have organized, largely through their community board organizations, to preserve and enhance those services. The power that has been given to the government is so great that that threatens the vitality of the ongoing organizations.

I'm sorry. I didn't want to interrupt you.

Ms. Davidson: No. Thank you.

1400

The Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. It was excellent, and I appreciate your thoughtful comments.

You were talking about accountability and the need for the minister to be accountable to the public, the need for MPPs to be accountable to their constituents when there's a health care issue. Like you, I think the political motivation behind Bill 36 is so as to create a political buffer between the minister and any problem that might exist in the health care system, whether it be a difficult decision that's been made to perhaps close a hospital or to integrate two services together or whatever it might be. And if an issue is raised in the House, if an opposition member raises these questions in the House, I would anticipate that the minister is going to say, "Oh, I had nothing to do with it. Talk to the local LHIN. They're the people who made that decision. I had nothing to do with that." Is that your concern?

Ms. Davidson: That's absolutely my concern, yes. You probably said it better. Absolutely, yes.

The Chair: Madam Martel.

Ms. Martel: Thank you for your presentation. I want to focus on the aspect of competitive bidding, because the minister in his opening comments tried to say that

essentially people who said this was going to be competitive bidding were providing misinformation and a few other adjectives that I won't get into right now. If you look in the bill, there isn't anything to say that they can't. So if the government meant that, you would have thought it would be in the bill.

Because you specifically referenced, because you had a personal example, I wonder if you can just comment on the concerns that you had watching competitive bidding operate in the agency that you were attached to and then what your concern would be if that was magnified to the other health care services that now fall under this bill.

Ms. Davidson: Absolutely. I did comment on the fact that the competitive bidding process was like it pulled away hours and time of workers who should be delivering services, but it also changed the focus of the organization. For example—I don't want to jeopardize anyone with what I'm saying here—the organization I'm talking about actually went after some money so that they could do something that they thought would make them look better to a provider of funds. So instead of focusing on their community, which they do in a fantastic way—and they still find a way to do that—they get sidetracked into trying to create something that will be attractive to someone they're doing a bid for. That's kind of what I'm trying to say. It does sidetrack the energies and the focus of the agencies that have done such an excellent job so far in focusing on communities and community needs and developing appropriate programs.

The Chair: Thank you very much for your presentation.

ONTARIO PHYSIOTHERAPY ASSOCIATION

The Chair: We will have the next presentation, the Ontario Physiotherapy Association; Dorianne Sauvé, please. You can start whenever you're ready.

Ms. Dorianne Sauvé: Thank you, Mr. Chairman, and thank you for the opportunity to appear before this committee. My name is Dorianne Sauvé, and I am the chief executive officer of the Ontario Physiotherapy Association. With me is Don Gracey.

I'm not sure whether it's an advantage or a disadvantage to appear this late in the committee hearings. I fear that you have probably heard everything there is to say about Bill 36, from every possible perspective.

We have given copies of my prepared remarks to the clerk, and I don't mind if you flip through them while I'm speaking. We will also be making a written submission. But rather than follow my prepared remarks, I think I'll make just a few points that are of particular interest or concern to the physiotherapy profession and thereby leave as much time for questions and dialogue as possible, because, as I said, I suspect you've heard it all before.

We have the same concerns as many others as to what is beyond the scope of Bill 36. By this I mean the exclusions in subsection 2(3) and the fact that inde-

pendent health facilities, medical laboratories, public health, in fact pretty much all of primary health care delivery, is not explicitly part of the LHINs jurisdiction. We don't see how the LHINs can do what they are supposed to do in terms of health service integration when so much is beyond their reach.

Community-based physiotherapy is in a no-man's land. We are neither excluded by subsection 2(3) nor included under subsection 2(2). We have asked the ministry for clarification as to where we sit and why, but we have had no response.

It is the OPA's position is that all physiotherapists in the public sector should be covered within Bill 36, regardless of the venue in which they practise. In fact, we believe that every significant component of the public health care delivery system should fall within the ambit of Bill 36. There should be no exclusions.

You have also heard many concerns that Bill 36 creates an uneven playing field between the for-profit and not-for-profit providers. We agree with those concerns, particularly as they relate to section 28. The OPA has no objection to the operation of for-profit providers in the publicly funded health care system, but we see no valid public policy rationale for giving them special status. If for-profit providers choose to play within the publicly funded system, they should play by the same rules as everyone else.

We also support those who are concerned that Bill 36 is really about centralization of control over the health care delivery system rather than the regionalization and local decision-making that we were told to expect. Bill 36 looks to us like the Minister and the Ministry of Health want it both ways: the apparent devolution of responsibility while retaining real control of the ministry.

This committee has asked previous presenters what powers the government should or should not have in LHINs. We believe the discretionary funding power provided by the ministry pursuant to subsection 17(1), the requirement for an audit by the Auditor General, the ability of the minister to require reports, coupled with accountability agreements and the requirement that the LHINs' integrated health service plans be consistent with the provincial strategic plan, provide the government with adequate control and direction over the LHINs. Beyond that, we respectfully suggest that this committee take the minister and ministry officials through the long list of additional powers the government would have under Bill 36 and ask them to justify their necessity.

As written, regionalization and local decision-making is an illusion. LHINs will have very little in the way of real independence. We think this will have negative implications for the governance of LHINs and for their relationships with individual community-based health service providers.

We have spoken to ministry officials about our concerns with the expansive governmental powers and how they might be used. We have been given assurances that they will be used carefully and in such a way that local decision-making is respected. That might be well for this

ministry and this government, but the health care sector and I'm sure other sectors are replete with examples of how legislation has been put in place with certain understandings as to how discretionary powers are to be used or how statutory provisions will be interpreted in practice. We have frequently been given assurances, "Oh, we'd never do that," or "That's how we intend to interpret that," only to find that a subsequent minister or government does exactly that or applies an unexpected interpretation. The fact is that the authorities provided to the government in Bill 36 could be used by this or any subsequent government to enforce completely centralized control over Ontario's health care system.

I would like to close my abridged remarks by talking a little bit about consultation. When the minister appeared before this committee, he was quite emphatic that there had been extensive consultations about the LHINs. Let me make two points in response. First, the consultation that our members attended amounted to the ministry telling the attendees what it was going to do. The ministry may feel this is consultation. We don't. Most of our members who attended came away very disappointed that they were unable to put forward ideas or to influence the direction the ministry was going in. Second, there has been no opportunity for groups like ours to consult with the ministry on Bill 36 per se. We have been invited to attend technical briefings, but there has been no opportunity to raise or address issues that we have with Bill 36. This is particularly important given what I said earlier, namely, that Bill 36, particularly in its centralization of control, is not what we were expecting from the ministry's consultations.

Mr. Chairman, that concludes my remarks. Don and I would be happy to hear any comments or any questions.

The Vice-Chair: Thank you for your presentation. We have almost seven minutes. We'll divide it equally between the three parties. We'll start with Ms. Martel.

1410

Ms. Martel: Thank you for the presentation. Let me phrase my questions this way: You're very critical of this bill and critical of the lack of consultation, and it's not because you have a vested interest, because you don't. Physiotherapists aren't going to lose their jobs or their employment one way or the other if this bill goes through. When you look at this, particularly your concerns with respect to the increased concentration, I can tell you that government members have tried to say that this isn't an increase in powers, that it's the same kind of powers the minister already has, that it's not an expansion. You were pretty clear that that's not the case. Maybe you want to expand a little bit further on the differences you see with respect to this bill and what might have come before.

Mr. Don Gracey: Let me make two comments about that. If you look at the long list of powers that the minister, the cabinet and various other ministers may exercise over LHINs, it's at least as much and in some cases more than the powers the government can exercise over one of its crown corporations, over its agencies,

boards and commissions. To say that LHINs have the capacity for local decision-making or whatever simply doesn't work when compared with the long list of powers. The other thing you've got to look at, I think, is from the bottom up: Look at the control the LHINs have over the health service providers: the accountability agreements, the funding arrangements, that they can transfer services back and forth. That power does not exist today. So I think it is a tremendous expansion of the ability of the government at Queen's Park to control the health care system; it's much more than what we have today. It may not be more than the controls the government currently exercises over hospitals, but it's more than they can exercise over long-term-care facilities now, it's more than they can exercise over health service providers now.

Ms. Martel: Secondly, you talked to the ministry, and the government said, "Oh, don't worry. We're not going to exercise these powers." You don't find a lot of comfort in that. Why is that?

Mr. Gracey: Let me give you an example. When your government passed the Long-Term Care Act in 1995 and it talked about the multi-service agencies, the MSAs, could anyone have believed at that time that that legislation would have been used to introduce community care access centres and managed competition? That's the kind of thing. I mean, if a power is there—when I was in government, we used to refer to it as Trojan Horse legislation. Once it's there, it can be used for whatever you like. If those extensive powers are there, they can be used by this government or any subsequent government however they choose. Whatever verbal undertakings may be given today really don't mean anything later on. If you look, for example, at some of the undertakings that were given when the Regulated Health Professions Act was going through committee in 1991-92, a lot of those went out the window immediately after it was proclaimed in 1993.

Ms. Sauvé: I'd like to comment too from the physiotherapy perspective. I think that those kinds of extensive powers—we have currently one of the few professions that work fairly extensively in almost every aspect of the health system that will be under the control of the LHINs, whether that be long-term-care homes, CCACs, in some cases community-based clinics, and hospitals, obviously, so any decisions that are made to those areas have a tremendous impact on our front-line providers. I think that is where our concern comes in in terms of these extensive powers.

Ms. Martel: Because you are attached to those agencies.

Ms. Sauvé: We're attached to those agencies.

The Vice-Chair: Mr. Arnott.

Mr. Arnott: During the election campaign in 2003, the Liberal Party promised not to create two-tier health care, but of course in the first budget there were a number of provisions, one of which was that the Minister of Finance announced the delisting of physiotherapy services, optometry services and chiropractic services.

What has happened in your sphere of activity since that delisting? If you could inform the committee of that, it would be most appreciated.

Ms. Sauvé: We were delisted, then we were partially relisted with an announcement that, effective April 1, 2005, we would have services for those under 18, over 65, and those under social assistance programs. Through the current system of designated physiotherapy clinics, what has occurred since April 1, 2005, has been a limited rollout of services to specific long-term-care homes that did not have services, and currently a limited rollout, at this point, to those who have a small amount of services. That's under way. There has been no improvement in community-based physiotherapy services for Ontario because there are only 95 designated physiotherapy clinics and they are still mostly located in metropolitan areas, the Golden Horseshoe, a couple out east in Ottawa and Kingston—nothing north of Sault Ste. Marie. So there has been nothing done in terms of community-based services since that announcement.

In actual fact, we're in a worse situation now because there's so little horizontal planning around physiotherapy services or any rehabilitation service in Ontario. There is a misconception out there that those services are available because of that announcement, so some hospitals have been reducing or cutting their outpatient services based on the fact that they think it's available in the community, but it's not. So in actual fact we're in a worse situation now than we were with the initial delisting announcement, because then everybody would have known there were no services. We're even worse off now with a partial relisting, because there's still a misconception that those services are available, and they're not.

The Vice-Chair: Ms. Wynne.

Ms. Wynne: I apologize. I came in just at the end of your presentation, but I have looked it over while the other folks were talking. The issue of the exclusions in the bill: Part of what we're trying to do by mandating the local health integration networks to engage the community, and particularly the health community in each of the areas, is that we're trying to get all of those voices into the planning process. Can you comment on that, firstly? Then secondly, this issue of centralization as opposed to decentralization: I understand the Trojan Horse analogy, but I also believe and know that what this minister wants to do is put into the hands of someone other than ministry officials at Queen's Park some control over budget and over the organization of the health care system. That's what we're trying to do. Could you comment on those two pieces, the community engagement and the need for there to be local input, which you seemed to agree with at the beginning of your presentation.

Ms. Sauvé: I'm not really sure how the exclusion component would achieve greater integration or community involvement.

Ms. Wynne: I'm saying, though, that the mandate—in section 16, the bill mandates each LHIN to engage the community, so that would be a way of having those

voices at the table. Can you comment on that piece? Maybe it's completely separate from the exclusion discussion, but can you comment on that community engagement clause?

Mr. Gracey: I think the exclusion issue is somewhat different from the community engagement issue. We have difficulty understanding that if there's going to be, through the health professionals advisory committee—if, for example, physicians and podiatrists are going to be on that, why should the services that they provide be excluded? It's the old joke that if you're not going to play the game, why should you be involved in setting the rules? There seems to be a dichotomy there. The government says, "We'll bring physicians and podiatrists into the planning process, but of course the LHINs can't have anything to do with the services they provide." With specific reference to physiotherapy, the question about the exclusion is, why? In terms of the community-based physiotherapy that Dorianne was talking about before, they are funded through OHIP in exactly the same way as physicians, podiatrists, optometrists etc., so why aren't they excluded? It's what Dorianne referred to as a never-never land.

In terms of the community-based decision-making, as I said earlier, if it works, that's fine. I can tell you, from a personal point of view, I now serve and have served for a long time on the board of a long-term-care facility in Markham. I will resign when this legislation is passed, because I do not see how my duties, responsibilities and liabilities as a director of that long-term-care facility can be reconciled with the role of the LHIN and the role of the minister.

Ms. Wynne: Thanks.

The Vice-Chair: Thank you very much for your presentation.

1420

CANADIAN PENSIONERS CONCERNED INC., ONTARIO DIVISION

The Vice-Chair: Now we have Canadian Pensioners Concerned, Ontario division. I don't know how many we have with us here; we have listed about five people. Are all of them here? Okay. There are two people. They'll mention their names when they come to the table. You can start whenever you want. You have 15 minutes; you can use it all, or you can use part of it and the other part for questions. I think she was here yesterday; she knows the game.

Ms. Gerda Kaegi: Yes.

Dr. Don Bellamy: Thank you very much. Ladies and gentlemen, I represent Canadian Pensioners Concerned. At the moment, I'm the president. My colleague here is also on the board.

The Vice-Chair: Sir, could you please provide your names? I have five names here.

Dr. Bellamy: I'm Donald Bellamy, and my colleague is Gerda Kaegi. We're both members of Canadian Pensioners Concerned, which was founded in 1969. It's a

national, voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

We have distributed for your reading our brief. I'm going to take the short way out, perhaps, and read the summary of recommendations, if you will allow me to.

With respect to the preamble, we would like to see the preamble to Bill 36 amended to include the following statements:

"The foundation of the integrated system is based on the following principles:

"(a) the five principles of the Canada Health Act," which are not there.

The Vice-Chair: Sir, if you could back up from the mike, it would be a lot better.

Dr. Bellamy: Am I too close? I usually am lectured for—

The Vice-Chair: This is a very sensitive microphone.

Dr. Bellamy: It's an excellent one; I would like to take it away with me.

Second, "community-based boards, responsible and accountable to the community and the government."

Third, "The local community has the legislated right to meaningful consultation/participation and determination of the services it needs in its local LHIN."

Fourth, "The primacy of non-profit provision of services over for-profit."

On the issue of the definitions in the legislation, our second group of recommendations is to amend Bill 36 to include the following under the section on definitions:

First, the term "entities" must be defined—a woolly word.

Second, under section 2.3, the order to integrate applies to for-profit entities as well as non-profit.

Third, non-profit service providers must not be required to integrate with for-profit entities unless there is no other option available.

Fourth, all providers of health services provided and funded by the LHINs and the Ministry of Health and Long-Term Care must be covered by the legislation. The minister must have identical powers to make orders with respect to not-for-profit and for-profit providers.

Next, on performance standards, accountability, community engagement, we would like to see Bill 36 amended to ensure the following:

First, evidence-based criteria founded on evidence-based performance standards must be used to evaluate the performance of each LHIN. The evaluation results must be public.

Second, each LHIN must be held publicly accountable to the community it serves as well as to the minister.

Third, LHINs' funding is based on the actual needs of the population and includes a number of variables such as socio-economic status of the population, health status, age distribution, the number of recent immigrants, ethnocultural diversity and so forth.

Fourth, each community must be consulted and participate in planning and setting the priorities of its LHIN.

The procedures for consultation must be part of the regulations. The ministry's strategic plan should be informed by the local LHINs plans.

Fifth, clarification is needed on the relationship between the public health departments and the relevant LHINs.

Finally, health promotion should be one of the critical priorities for each LHIN.

With regard to the composition and practices of the LHINs, we would like to see Bill 36 amended to ensure that, first, the board of directors must number not less than 21 nor more than 25, and should reflect the nature and complexity of the community being served.

Second, a seniors advisory committee will be one of the committees required under the regulations for each LHIN.

Next, the aboriginal community has representation on those LHINs serving a significant proportion of their population.

Fourth, the board of directors must be required to meet for a minimum of 10 meetings a year, and these meetings must be open to the public.

Fifth, the Auditor General should be required to perform a comprehensive value-for-money audit on all of the LHINs on a periodic basis or upon request from the Legislature.

Funding and accountability: We urge amendment of Bill 36 to ensure that the government is required to provide to the relevant standing committee of the Legislature detailed comparisons between the current level of funding for health services in each region of the province and the funding apportioned out to the LHINs.

Second, funding and accountability agreements be set for a minimum of three years.

Third, ageism is prohibited in all forms of planning and service delivery.

Fourth, each LHIN should have an independent ombudsperson's office that reports to the Legislature.

Integration and devolution:

We urge that Bill 36 be amended to ensure that, first, effective and responsive service delivery is the primary focus of the LHINs.

Second, the public has the right to appeal an arbitrary delisting of services. If a decision on delisting services is made, it must come after extensive public consultation.

Third, the public and non-profit service providers have the right to appeal a decision to transfer services to another provider.

Fourth, the use of competitive bidding to select appropriate service providers for each LHIN is not used for the funding of service providers. The selection criteria must include a proven record of the quality and continuity of care provided to care recipients.

Far from meeting the resonant words of the preamble, this draft legislation leaves much to be desired. We do not see it as the government fulfilling our vision of an integrated health system that delivers the health services that people need, now and in the future, as in the preamble. Our vision sees an integrated system focusing on

wellness and health promotion while ensuring the real care needs are being met. We believe that such a vision can be achieved if we listen to those being served and develop a responsive and responsible system.

Thank you very much, Mr. Chairman.

The Vice-Chair: Thank you for your presentation. We have three minutes left. We can start with Mrs. Van Bommel.

Mrs. Van Bommel: Thank you for your presentation. It was certainly very well thought out and gives us a lot to think about.

One of the things that I notice in recommendation 5 is that you feel that the board of directors should be between 21 and 25 members, and currently it is set at about nine. Can you tell me why you feel that it needs to be that large?

1430

Ms. Kaegi: Yes. I think it's quite straightforward. The LHINs areas are very large and some of them encompass a very large, diverse population. We do not see how a board of nine can possibly represent and truly hear from the community with that size of a board. If I could explain, I sat on the district health council in Toronto. We had a board of 25, and even we struggled to meet the representation needs of the population of this city. Some of the LHINs are over a million people, so we felt very, very strongly that the boards have to be bigger. Nine is far too small.

Mrs. Van Bommel: You mentioned things such as seniors advisory committees and the aboriginal community. Do you feel that there should be guidelines as to who should be members, to be sure that we cover all the groups that have an interest and should be represented there?

Dr. Bellamy: Yes, we do.

Ms. Kaegi: Seniors are the major consumers of health care dollars and they are the ones who tend to be marginalized, and we can document that if somebody wants. But "first bed available" is being done now to seniors; hospitals throw them out. Even though the rules say they can't do that, they're kicked out to the nearest available bed. What we need to have is some watchdog, if you like, and some voice for the population that is, we believe, quite vulnerable. That, of course, is our role as Canadian Pensioners Concerned.

The Vice-Chair: Mr. Arnott.

Mr. Arnott: Thank you very much for your thoughtful presentation this afternoon. It's very interesting, and you've put a lot of effort into it. Your organization deserves a lot of credit for bringing this advice forward to us.

I had a similar question to the one Mrs. Van Bommel asked about the size of the board and the number of people, but you've already addressed that and answered it. I did have another question. I'm just looking for the recommendation here.

The value-for-money audit: There have been a number of presenters who have come forward and said, "If this is just another level of health care bureaucracy, we don't

need it. There's enough bureaucracy in health care already." Is that part of your concern, as well? Is that why you are asking that provision be made for the Auditor General to order a value-for-money audit at any time? Is that what you're getting at here?

Ms. Kaegi: CPC, in the past—if I may speak, Don—has found that the reports from the Auditor General have been extremely thoughtful and very useful. We believe, especially when a new structure, a new organization, has been set up, it would be very useful for the Legislature and the public to see that kind of critical outside review of what has happened. That's one of the reasons behind that recommendation. We have in fact asked for that kind of review of a particular service in the past, and his report achieved what we had hoped to achieve: It was stopped.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation. I wanted to focus on your recommendation 7(c), "The public and non-profit service providers have the right to appeal a decision to transfer services to another provider." The legislation is silent on any form of public response to an integration decision or order at this point, and the service provider's right is only for reconsideration to essentially the same body that made the negative decision in the first place. What were your thoughts around this section? Did you have in mind a structure or a process that you think would be better?

Ms. Kaegi: In the brief, we refer to a process that we suggest could ultimately come to a standing committee of the Legislature. In fact, if there can't be resolution, we think there has to be a right of appeal. It has to be long enough, not quickly done within 30 days so that nothing really can be achieved. We believe there must be enough time to launch a formal appeal. Ultimately, coming to a standing committee of the Legislature might be the final avenue, but we feel there's got to be a process external to those who have already made the decision. I know you are busy people, but it's one way to get outside the system to be able to hear a dispassionate presentation on an appeal. I don't know if that was a clear enough answer.

The Vice-Chair: Thank you very much for your presentation and for your answers.

CANADIAN UNION
OF PUBLIC EMPLOYEES,
LOCALS 4308 AND 3896

The Vice-Chair: Now we'll move on to our second person, Kelly O'Sullivan. Kelly, you have 15 minutes. You can use them all or you can divide them between speaking and answering questions.

Ms. Kelly O'Sullivan: I thank the committee for the opportunity to speak to you about Bill 36 and the local health integration networks. My name is Kelly O'Sullivan and I'm a president of two CUPE locals here in Toronto, CUPE 4308 and 3896. I represent workers at three community-based, not-for-profit agencies here in Toronto: Central Neighbourhood House, Senior Peoples'

Resources in North Toronto and Toronto Homemaking Service.

In total, close to 300 workers provide services at these agencies each and every day out in our community. The majority of our workers are personal support workers and community workers who are responsible for supporting seniors and people with disabilities or mental health issues to live with independence and dignity in their own homes. The range of services we provide includes personal care, adult day programs, supportive housing, meals on wheels, social work, community dining programs, transportation, advocacy and support. Our work, our agencies and the very communities in which we live and work will be directly impacted by Bill 36 and LHINs.

As a front-line worker in the community, I have seen first hand the devastating impact of the competitive bidding model in home care. This is the first area I wanted to focus on for the community. When it was introduced in 1997 by the government, the impact on our workers and clients was immediate. During bargaining for us, one of our employers tabled concessions and cutbacks to already low-waged personal support workers because they had to be able to compete. They wanted to do more, but the bottom line for them was being able to compete in the sector against the for-profit companies.

Another employer stated that any wage increase that we might try to bargain with them for would mean that they would not win a contract with the community care access centre. They issued us a gag order, because to publicly speak out about that fear would be perceived as labour unrest and, once again, it would damage their attempts to secure a contract.

The focus for our employers became a contract at any cost, and the cost was borne by the personal support workers who had to carry out this work in the sector. They have seen their wages flatlined for over 10 years, with the majority—even though they are health care workers who provide 70% of the care in the homes—not having access to health benefits. I'm talking about basic benefits here, a benefit plan. Our workers, for the first time in 30 years, after we were forced out on strike, were able to access a basic benefit plan. The majority of workers in this sector do not have that access. There is inadequate sick leave, a health care worker receiving sometimes only 40 hours of sick leave a year, and that's those who are fortunate to have that in the not-for-profit sector. Almost none of these workers has a pension plan. Competitive bidding has resulted in wages being driven down even further, work conditions deteriorating and workers expected to do more for less.

Those we provide the services to have also felt the impact. Reduction in service, cutbacks to hours of care, waiting lists and lack of support have meant that many seniors and people with disabilities are struggling to be able to maintain a home and are entering institutions prematurely. In addition, families and informal caregivers are left with an increased burden of care that it is not reasonable to expect them to meet.

In 2006, the not-for-profit, community-based agencies and clients we serve are still being negatively impacted by this model. Since 2004 alone, 22,000 clients have been affected by the loss of contracts through competitive bidding, and over 1,000 workers have been laid off or have lost their jobs completely. At least 24 not-for-profit service providers, many with 50 to 100 years of standing in local communities, have closed their doors. Once again, personal support workers in the community who were already working for low wages lost those jobs, lost benefits, seniority and guarantee of hours they may have been able to gain after years of service for an agency.

In one loss of a contract, a worker was at an agency and had been at that agency for seven years. A month later, she was serving the same client, but at a lower wage, with a loss of her benefits and having to work for another for-profit employer. That was a fortunate client who was able to maintain their worker. In fact, many clients who had had the same worker for years—I represent workers who have been in this sector for 15 years, some of them. For clients, that personal care that they receive from the same worker consistently, week after week, year after year, is important, and they're now forced to accept care through strangers. I have to say, from my perspective and that of the workers I represent, the only gain that has come from competitive bidding has been the opportunity for private companies to make money off the vulnerable, ill and frail seniors and people who require support in their home.

1440

I ask that the committee ensure that Bill 36 is amended to include a provision that would eliminate existing models of competitive bidding and not allow for the expansion of competitive bidding models to be introduced in any health or community support service.

Another concern I wanted to bring to the attention of this committee is the role of the community care access centres. Currently, CCACs are responsible for coordinating and referring to service providers in a number of areas of health, including nursing, personal care and occupational therapy. This is not an exhaustive list. It is my understanding that Bill 36 will not only maintain the CCAC structure but also possibly expand the services it contracts out and coordinates. The issue here is another layer of bureaucracy for service providers, workers and those who receive service to deal with. Let's think about this: Money from the Ministry of Health will go to the LHINs, the LHINs will then take that money and give it to the CCAC, and the CCAC will allocate that money to various service providers. At the end of the day, what's left over for workers and clients? It's just the crumbs, that's what's left for us. I ask that the committee review the role, responsibility and mandate of the CCACs and not allow another layer of bureaucracy to encroach on already limited funding for the home and community care sector.

The final area of Bill 36 I wanted to focus on today is the issue of community engagement and control. I put

forward a challenge here today to every committee member: Before you make any final decisions on this bill, connect with your own communities. At random—and I mean at random, not loyal people who show up in your constituency office every day—speak to at least five of your constituents and ask them if they have ever heard about the local health integrated networks. I think you'll find the majority of them have not heard anything about it. Then ask yourself if you believe, as an elected official, if Bill 36, LHINs, and the restructuring of health care has been done publicly and with community engagement. I can guess what the answer is.

I also ask that the committee ensure that Bill 36 includes the democratic election of LHINs directors by all residents in the LHIN geographic area and that all meetings of the board be open and accountable to the public.

I wish to thank the committee for listening to the concerns and suggestions I've put forward on behalf of the personal support and community workers I represent. All of us strongly urge the committee to recommend to the Minister of Health and the government that the bill in its current form needs to be set aside and that a real and significant consultation process with local communities, health care workers, not-for-profit service providers and the public take place to assess how health care should and could be transformed to all of our benefits. It is with an inclusive, democratic, open and accountable process that change should happen. Thank you.

The Vice-Chair: Thank you kindly for your presentation. We have about four minutes, divided equally between the three parties. We'll start with Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. You mentioned, in the context of your talk, that you feel that a lot of people don't know this bill is before the House, they don't know what a LHIN is, they don't know what a local health integration network is, and I would concur with that. From the discussions that I've had with people in my constituency when I tell them—first of all, when the House isn't sitting, they don't think we're doing anything, which isn't the case; we're down here doing public hearings, in this case. When you talk to them about what this bill is all about, there is a great deal of interest when you start engaging them about it, but until you explain what's happening, they aren't aware. I think the government has a real obligation to communicate that. Do you have any suggestions as to how we might do a better job of getting word out that this bill is before the legislature and what the implications may be?

Ms. O'Sullivan: By getting the word out, I think it's more important to stop this before it gets steamrolled through and actually engage in a full consultation process with our communities. I would argue that all members here, as elected representatives, have that responsibility, regardless of the party they are sitting with. That would be the practical way to do it.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation today. I want to focus on competitive bidding, as I have many

times already in the public hearings. While the minister says this is not in the legislation, of course there's nothing in the legislation that says it won't be used. I have encouraged the government to bring forward an amendment to make it absolutely clear that competitive bidding will not be used as a model for acquisition, obtaining of health care services that the LHINs are responsible for.

You gave us a very clear description of how devastating competitive bidding has been in the sector and related a very personal experience with respect to the members you represent and, frankly, the clients, the patients they are dealing with. Over and above that, I guess it's also the issue of, where does the money go in home care when you have competitive bidding? Because there certainly has been extensive analysis on how much money has been taken up in the system by every agency putting in requests for proposals, having the consultants do that, and then how much money doesn't go to patients when you have a for-profit provider that's in the picture. Some of that money that should go to patient care ends up being diverted to that for-profit provider.

What are your concerns, having seen it first hand in home care, about a potential broader application to other areas of the health care sector?

Ms. O'Sullivan: I think the direct effect which I focus on as a front-line worker is for those who are most vulnerable. What we saw in our sector when the for-profit players became more prominent was their inability and/or refusal to work with hard-to-serve individuals. If it was basically costing them too much money to work with an individual who might have a mental health or complex situation, it ended up being the not-for-profits that went in and were able to do the work, because we're not there to make money. We're there because we have a philosophy, we have a mission and we have a mandate to provide services to clients. It's not about the bottom line. It's about finding a way to provide service to meet the needs and to support that individual. The for-profit providers would just walk away. They literally would walk away and say, "We're not dealing with it. We can't do it. Sorry. No, thanks." For that to happen, what happens when we're no longer around? When you continue to have a model that pushes not-for-profits into closure, who is going to work with those individuals in our community who are most at risk?

The Vice-Chair: We will move to Ms. Wynne.

Ms. Wynne: Thanks for coming today, Kelly. I appreciate it.

I just wanted to talk about that interesting point you made about people not knowing what a local health integration network is. Starting in the spring and fall of 2004, the ministry and the minister started to have consultations on this bill—430 submissions on LHINs so far; 4,000 people registered for workshops and attended those workshops. The ministry also established a provincial action group to provide advice on the design and implementation of LHINs, and in that group were provincial associations representing home care, community

support service providers, community mental health service providers, hospitals, public health agencies and a number of others. Then, between December 2005 and just this last month, January 2006, there were 48 community and union groups who were part of a technical briefing on the bill in order to allow them to give their feedback.

It's not that I'm challenging your contention that people don't know what LHINs are yet, because that's probably for the most part true, but after that amount of consultation—we've had six days of hearings and we're going to have seven in total after tomorrow—I think the knowledge level of what a LHIN is is going to have increased. I think that until LHINs are set up and start functioning, the general public won't know what they are. To me, given the efforts that have been made at public consultation so far and given that section 16 in the bill gives LHINs the mandate to continue to have community engagement, given all of that, I think people know what LHINs are, and that will be a good thing in terms of their ability to connect with the health care system. I don't know if you want to comment on that, but I just wanted to outline the kind of consultation that has been done up until now.

1450

Ms. O'Sullivan: Thank you for referring to that. I guess for me it's kind of like the horse before the cart. We're going to have the LHINs, we're going to have Bill 36, and then we'll let the community tell us and make sure that the community has a full understanding. When you talk about 4,000, how many millions of people actually live in Ontario, and who were those 4,000 people? Were they selected and solicited? In your own constituency, did you have a community forum?

Ms. Wynne: Actually, I did have a community forum. I let people know that the consultations were happening, and I made sure that anybody who wanted to take part was connected, so in fact—

Ms. O'Sullivan: And how many other MPPs did that?

Ms. Wynne: I don't know the answer to that.

Interjection.

Ms. Wynne: Khalil did it. I think it happened pretty much across the province. And not everybody is interested in having this conversation. But, Kelly, I wasn't saying that the bill passes and then people get informed. I was trying to say that there has been an upfront consultation, and the very nature of the LHINs is that that consultation will be ongoing. That was the point I was trying to make.

Ms. O'Sullivan: I would disagree with your perception about an upfront consultation, because I'm active in my community, I'm active as a union member—you know, I was not aware of your meeting with 4,000 people, and I certainly didn't receive any information about being involved. I'm one community member and I actually live in the minister's riding.

Ms. Wynne: I'm glad that you've had the chance today to put your voice on the record, and that discussion will continue as the LHINs get set up.

The Vice-Chair: Thank you, Kelly.

I wonder if the Ontario Health Coalition, Lindsay chapter, is here. Is anybody here from Lindsay chapter? No.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0N

The Vice-Chair: We'll move to the second one, Roseann Clarke. Would you mind mentioning your name and your friends' names for the record?

Ms. Roseann Clarke: My name is Roseann Clarke. On my left is Pat O'Brien and on my right is John Van Beek.

Good afternoon. I am a clerical health care worker at North York General Hospital and the designated certified worker co-chair of the joint health and safety committee. I am also a union steward for the Service Employees International Union, Local 1. With me is Patrick O'Brien, the steward for the service unit at the hospital.

As a union steward, I represent approximately 1,400 health care workers. As the certified designated worker co-chair of the joint health and safety committee, I represent a total of 3,000 workers at the same institution.

Bill 36 will remove any local control over health care and place that control solely within the power of the Minister of Health and Long-Term Care and the Ontario cabinet, who in turn have placed the power to integrate, amalgamate and privatize health services in the hands of unelected political appointees, many of whom have no background in health care. It is they who will decide our future.

My job is important and, might I say, essential. As a unit secretary, my job is of the utmost importance as it provides the clerical support that allows physicians and nurses to focus their attention on the patient at the bedside. The unit secretaries transcribe the physician's orders and communicate them to the nursing staff, to other health care professionals and to every other department in the hospital. We are trained, dedicated health care workers whose jobs are on the chopping block if this legislation is enacted.

The only thing that's saving us right now is the non-contracting-out language in our union's collective agreement. Because of this language, the hospital cannot contract out our work if the result is a layoff. Hospitals, including North York General Hospital, have become very creative in their human resources strategies to get around this clause in our collective agreements. The hospital will reassign employees of the department it wants to contract out to other duties in the hospital or offer employees incentive packages to leave. The hospital will then contract out those functions, particularly dietary and housekeeping services, to foreign-controlled, private, for-profit enterprises such as Compass Morrison, Sodexo or Aramark. Employees for profit operators earn less than \$10 per hour, have no benefits and no pensions.

The Minister of Health, George Smitherman, has been quoted as saying his mission is to reduce the health cost

curve. Sadly, he is going to do so, as Bill 36 demonstrates, on the backs of workers like me. George Smitherman does not consider clerical or service workers to be vital, front-line components of Ontario's health care system. The most vulnerable workers in the health care system are being targeted by this government to sacrifice the most so this government can contain health care spending.

I object to my—

The Vice-Chair: Excuse me, can you back off a little bit from the mike?

Ms. Clarke: Okay.

I object to my public health care dollars going to foreign, private, for-profit companies to enhance their profits. It is undemocratic to allow nine LHIN board members to decide what community gets what health care services and which health care workers have a job and which do not.

I do not see how this legislation will provide better health care to Ontarians. The long wait times in the emergency rooms are not caused by health care workers; patient referral patterns are set by doctors. The previous government integrated and amalgamated local hospitals. When the hospitals were amalgamated the bureaucrats, in their infinite wisdom, closed beds and decreased the availability of care to everyone. The result was increased wait times in the emergency rooms, and health care workers had to do more with less.

Health care worker jobs are the most risky of all occupations. Not only are they subject to infectious diseases, but they also have a greater amount of back and repetitive strain injuries from lifting patients. The speed-up of workplace duties has led to exhaustion, stress and burnout.

Let's not forget SARS. I would like to take you back to the spring and summer of 2003, when we had the SARS outbreak. At North York General Hospital, 42 health care workers were struck down by SARS. This virus was non-discriminatory in whom it attacked. Every discipline at the hospital was affected: doctors, nurses, environmental services, central stores, dietary, portering and clerical staff.

I was newly appointed by my union to the joint health and safety committee. The JHSC was given the daunting task of investigating this outbreak. One of the hospital's staff died as a result of having contracted the disease. It became apparent that there was no effective infection prevention and control program in place and that the funding for this kind of program was being severely skimped. There was only one IPAC practitioner for all three sites of North York General Hospital: the seniors' health centre, the general site and the Branson site. Since then, extensive training has taken place to ensure that all staff are knowledgeable and diligent in their IPAC procedures.

What we learned from SARS was that it is imperative to have well-trained, dedicated and adequately compensated workers at all levels so that the public is confident that they are protected from infectious diseases. If our

jobs are contracted out to for-profit companies whose only mandate is to cut costs and make a profit, then quality standards in our health care institutions will be sacrificed. Do you think that minimum-wage workers would risk their lives to come to work every day in a SARS environment as we did?

What SARS taught us is that an enormous amount of planning is required to run an efficient health care system. The type of planning and accountability measures that Bill 36 envisages only relate to the bottom-line financial outcomes, and not quality-of-care standards.

North York General Hospital is currently in negotiations with Compass Morrison, a foreign-based, private, for-profit company. The proposal is for a 10-year contract with North York General Hospital to manage our in-patient food services and retail food services departments. The workers in the dietary department, many of whom have worked at North York General Hospital all their lives, are to be displaced in order for Compass Morrison to bring in their own, non-health-care employees. Compass Morrison employees are not health care workers. Therefore, there can be no accountability from these workers to the hospital.

1500

The Guardian newspaper, in a late 2004 survey, found that the Compass group paid employees in Britain—a group of 412,500 employees—an average of 9,406 pounds per year. The vast majority of Compass employees earned minimum wage and well below the average salary in Britain of 24,600 pounds per year.

In British Columbia, the Vancouver Island Health Authority let go 1,000 health care workers and contracted out their housekeeping and food service jobs to Compass Group Canada. This deal was worth about \$25 million a year, and the Vancouver Island Health Authority says it will save \$10 million over the next five years as a result. How will it save? By cutting wages in half. Workers, having earned \$19 per hour, are now being paid \$9 to \$10 per hour. They have no benefits and no pensions.

The Compass disease is fast spreading into Ontario. North York General is just one example. Contracted-out cleaning services in the National Health system in Great Britain found companies not paying overtime or sick pay, no pensions and only 12 days of vacation per year. Food was transported from more than 200 miles and then reheated for hospital patients by contracted dietary service providers. This practice is also creeping into Ontario's hospital sector.

Several hospital cleaning contracts were axed by hospitals for failing to come up to regulated hospital cleaning standards. In September 2002, porters at the Kingston Hospital National Health Service Trust were told they must bring their own cleaning materials to work with them because the firm significantly underpriced its bid for support services at that hospital.

In July 2002, the South Glasgow University Hospital National Health Service Trust terminated a cleaning contract Sodexho had with the hospital and brought the cleaning service back in house, after three deaths at the

hospital. An investigation confirmed an outbreak of salmonella caused the deaths, and the hospital blamed Sodexho as an inadequate contractor.

Reports of inadequate standards continue to pile up against these for-profit hospital service providers. I ask again, do you really want to transfer our public health care dollars to for-profit firms offering inferior services?

At the end of the day, as with public-private partnerships—or alternate financing initiatives, as this government prefers to call them—it always costs taxpayers more in the end. With the contracting out of hospital non-clinical services, not only will taxpayers be ripped off, but hospital service workers too will pay the price.

We already pay up to \$900 per year in the Liberal health tax. Every hour we work, 50 cents goes to this government's health tax. Now you expect us to pay even more, by sacrificing our jobs.

I would like to go forward to item 7.

Mr. Patrick O'Brien: Maybe Roseann can rest her voice a minute. I would like to address number 7 here, and I would really do it in very layman terms.

I have been a hospital employee since 1973. I've worked at North York General Hospital all of that time. In my own observations, I know the community takes pride in its hospitals, but at the same time, the "H" above hospitals stands for "hospital," not "hotel." In my own observations over the years, I've seen enormous amounts of money actually being spent on luxurious trappings for hospitals: enormous main lobbies that cannot be heated properly in the wintertime, and in the summertime it's way too hot. I see all the furniture being brought into the hospital, the luxurious boardrooms and all of these things. So my question really is, where are the priorities? Where is money actually being spent?

I understand very well that health care is one of the largest budgets, next to education, and there have to be ways to reduce that cost, but it should not be on the backs of the ordinary workers who are delivering a very important service for the patients, because my question really is, what does all of this have to do with direct patient care? And it needs to be noted. Thank you.

The Chair: Thank you very much for your presentation. There is no time for questioning.

ONTARIO HEALTH COALITION, LINDSAY CHAPTER

The Chair: The next presentation is from the Ontario Health Coalition, Lindsay chapter. James Mulhern, please have a seat. There is 15 minutes for your presentation, and if there is any time left, we'll be happy to ask some questions or make comments. Please start whenever you're ready.

Mr. James Mulhern: I just wanted to thank you for allowing me to be here and make a presentation. I'm from Lindsay local health integration network, region 9.

I want to begin by saying that the Ministry of Health and Long-Term Care has developed an act entitled the local health integration act. "Local" itself, if you want to

look at the word, the dictionary defines "local" as "of a limited area or place; local governments." If the minister went a little further and used the word "localized," Webster's dictionary defines "localized" as "to restrict or be restricted to a particular area or part."

The Ministry of Health and Long-Term Care has divided the province of Ontario into 14 regions, with five of the regions serving a population larger than five Canadian provinces. A sample travelling distance within the same local health integration network is, for example, from Haliburton to Scarborough with a distance of 203 kilometres, with a travelling time of two and a half hours; or Parry Sound to Timmins, with a distance of 468 kilometres, with a travel time of six hours; or Kenora to Thunder Bay, with a distance of 491 kilometres, with a travel time of six and a half hours. This all depends on the driver, the road conditions and the weather.

I fail to see where the definition of "local" or "localized" really applies to the local health integration act, Bill 36. My chapter of the Ontario Health Coalition submits that the local health integration act has nothing to do with local or the community, but more to do with centralization. The local health integration act gives the Ministry of Health and Long-Term Care the power to restructure the health care system in Ontario and to contract out.

If we go a little further, the word "integration" is defined in Webster's dictionary as "1. to make into a whole; unify; 2. to join with something else, unite; 3. to open to all ethnic groups." This would be a great idea if this is what the Ministry of Health and Long-Term Care was planning, but the local health integration act, Bill 36, fails to integrate all aspects of Ontario's health care system. The act includes both clinical and non-clinical services, hospital—including labs—long-term-care facilities—for- and non-profit—community care access centres, community support services, community health centres, mental health and addiction services, and the University of Ottawa Heart Institute, but fails to include physicians, ambulances, laboratories, specimen collection outside of the hospitals, independent health facilities, homes for special care, public health, provincial drug programs, psych hospitals and defined specialists like podiatrists and optometrists. The Ministry of Health and Long-Term Care has excluded a major portion of Ontario's health care system. How can you have an integrated network system when you exclude a major portion that could give the—okay, where did I go here?

1510

The Chair: Just tell us what is on your mind, because we have it in writing here.

Mr. Mulhern: The major portion is submitted—the health system, doctors and all that. They can give the greatest input, and they also give us the service. So you've excluded a major portion of our health care system. They should be put in. They should be part of the system if you're going to continue with this act.

Community care access centres, with this act, are going to be amalgamated, merged and eliminated. We

have 42 of them and they're going to be merged to align with the 14. What's going to happen with the board members on those community care access centres? There's going to be more chaos with home care. With the community care access centres and a lot of the decisions with health care made further from the communities, it is diminished. Like I said, it's not local anymore.

The networks themselves fail to address the real drivers of the health care system, which really create the major expense. The ability of the community to influence which services are offered locally is diminished. It doesn't say anywhere in the act that the community and the agencies have any input, especially in hospitals, into what's going to be cut or given or what services are going to be offered. Even in the strategic plan for the health care system, according to the legislation, "The minister shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions for the health system." There is no provision for any public consultation or process for this plan.

In my area, we had one public meeting and it was to find directors and to give out the information, and that's it. There hasn't been any information about public consultation or even any meetings at all about the strategic plan and where he's going with this.

The legislation itself defines "integration" in the way that we would define "restructuring," as the following: create partnerships; transfer, merge and amalgamate; order providers to start or cease provision of services; order providers to dissolve or wind up operations. It's the same thing in housekeeping in the hospitals or any agencies. There's no say that we have as to whether or not they should be closed or continue.

We have a few concerns:

(1) The provisions for democratic input and community control are weak or non-existent. The legislation supersedes a lot of democratic safeguards that were set out in other of legislation. The Minister of Health is not held to any democratic process for his strategic plan or his restructuring decisions. The provisions for community input are vague and left to regulations.

(2) The legislation facilitates privatization. Cabinet is expressly given new powers to order wholesale privatization of non-clinical services. In the act there is no protection or promotion of non-profit or public delivery of services. In fact, the legislation empowers the minister to order these services to be closed down but does not give him the power to do the same with for-profits. The local health integration networks may move funding, services, employees and some property from non-profits to for-profits. There is no definition in any Ontario legislation of what constitutes "non-clinical" services. Even under this legislation, cabinet is given the power to define these services as broadly or as narrowly as they wish.

(3) The principles governing the direction of health restructuring and accountability for the government are inadequate. Although all health providers covered are made accountable through service accountability agree-

ments to be backed by court orders, the ministry itself is held only to the undefined principle of acting in the public interest in the preamble to the legislation, and it's not legally binding.

The Canada Health Act principles of comprehensiveness, universality, accessibility, portability and public administration are not included at all. In our opinion, they should be. If you're going to continue with this act, they should be. There is also a deep concern for the public interest when the health minister indicates that his strategic direction is to centralize and consolidate hospital services and community mental agencies.

Under the provincial wait time strategy, the ministry is implementing a competitive bidding system for hospital services such as cataract surgery or hip and knee replacements. When competitive bidding was introduced into the home care sector by the previous government, it created a lot of chaos. A lot of non-profit agencies like VON could not compete, so they had to close up shop in that part of the sector, home care, and a lot of the for-profit providers continued on. The results of competitive bidding also includes constant turnover of employees, lack of continuity of care, low wages, shortages of skilled workers, high cost and a downward pressure on wages and benefits.

I work at a college, but the company that I work for is getting into some of the hospitals, like Sodexho. Like the previous presenter said, workers there may have been earning maybe \$17 or \$18 an hour or more, yes, but this company, Sodexho, comes in and knocks everybody's wages down, either in half or even less, close to minimum wage. I can barely live on what I'm making now because of that, and I don't think they can.

(4) The legislation itself sets up an extra, expensive administrative tier for no clear benefit. The 14 local health integration networks' boards will operate like regional ministries with awesome powers, with heavy administrative requirements and little public accountability for improving the health care system.

The Chair: Conclusion, please.

Mr. Mulhern: Under the legislation, the local health integration networks are not accountable to their communities but to cabinet. The board members are appointed by cabinet. There is a very high cost of administering just the board itself and not giving out money at all to the various agencies and the hospitals. The board members themselves, the CEOs and directors are creating a high cost just for them doing their work.

The Chair: Thank you, sir. Thanks very much for your presentation. As I said, we have your written material, but there's no time for question because you went over the time. Thanks again.

The next presentation is from the Ontario Public Service Employees Union, Local 269, Hamilton Victorian Order of Nurses, Lois Boggs. Is Ms. Boggs here? No.

We'll go to the next one. Is Aubrey Gonsalves present? No. Ukrainian Women's Association of Canada, is anyone here? Could I ask, are any of you here to speak to us today? No.

We are ahead about 15 minutes, so maybe what we can do is take either 15 minutes to go back to our offices and work, or five. Madame Martel, what would you recommend?

Ms. Martel: Ten at least.

The Chair: You have the right to tell us what to do for the next 15 minutes.

Ms. Martel: My office is close and I can get back there, but everybody else's probably is not.

The Chair: Let's take 10 minutes. Okay? So we'll be back here a few minutes before. Thanks.

The committee recessed from 1520 to 1549.

AUBREY GONSALVES

The Chair: Our next presentation is from Mr. Gonsalves. Would you please have a seat. You have 15 minutes to make a presentation. If there is any time left, we will be able to ask some questions and/or make some comments. You may start any time you are ready.

Mr. Aubrey Gonsalves: My name is Aubrey Gonsalves. I'd like to thank you for paying attention and listening to me.

I'd like to focus on four aspects of the LHINs: first, the governance structure; second, the LHINs' boundaries; third, the need for consultation; and fourth, concerns about privatization and contracting out.

My understanding is that the local health integration networks, or LHINs, board members will be appointed. This is not a democratic process. Further, there is no clear definition of who sits on these boards. What would the makeup of the boards look like? Would there be doctors, business people, service providers, or individual citizens like myself? Who? I don't know. What would their primary concerns be? Would they focus on the health services provided, or would they focus on saving money? In the past, looking at government appointments to boards, it is clear that it is not what you know but whom you know.

Further, the LHIN boards are not accountable to the population and the people whom they represent, but rather to the Minister of Health. We have seen through the community care access centres that complete ministerial control over local health authorities does not work. In fact, the cost of providing home care has gone up, not down. The citizens of Ontario believe that Ministry of Health money is better spent on improving our health services and not on unnecessary administration costs or salaries.

I make a recommendation to this committee that democratic selections of LHIN directors be made and that there be legislative requirements that each LHIN establish a health sector employee advisory committee made up of union representatives and representatives of non-union employees.

The second issue I'd like to discuss today is geographic boundaries. These proposed structures are not local, they're not based on communities and they do not represent community interests. There is no legislative

guarantee that all services will be provided in every LHIN area. Also, these boundaries would negatively impact rural areas, specifically the elderly and people on social assistance. These low-income earners would have great difficulty affording transportation to travel to receive medical services.

I make a recommendation to this committee that LHIN boundaries must reflect real communities, that there be a requirement in the legislation for extensive public consultation on the existing boundaries and that there be a requirement in the legislation that guarantees that all regions have the same health services with the same access to them.

Community health centres that are run by community boards elected by community residents and consumers of the health services are responsive to the needs of local communities. These will be integrated under the LHINs. These are the only real form of community health care that will disappear under this legislation.

The third area I'd like to talk about is the need for meaningful consultations. Over the past couple of days, I have spent time watching channel 70, and I have heard a lot of deputations to this committee from individuals, agencies, unions and the like. There has been a strong message: People want to be involved and consulted in this process. This process for introducing and moving toward making the bill into law has been very fast, with little consultation but with large amounts of change to our health care system contained in the bill. The people of Ontario have a right to be knowledgeable about their health care services and about any proposed changes the government wants to bring about under LHIN restructuring.

But most people in Ontario have never even heard of LHINs, let alone understand the potential outcomes of these massive changes. It is clear that the public does not want any decrease in our health services or longer waiting lists for services. Public consultation is the cornerstone of good policy. Without true, meaningful and thorough public consultation, any restructuring of the health care system will bring about significant backlash from the public.

I'd like to make a recommendation that there must be a commitment from the current government, like the commitment they provided during the last provincial election, to strengthen and support health care in Ontario.

The final area I'd like to talk about is my concern over the privatization and contracting out of our health care services. The vast majority of the citizens of Ontario do not want privatization of their health care system. The LHINs structure creates a split between the purchasers of service and the providers of service.

Competitive bidding has been a disaster no matter what sector has been subjected to it, since its main objective is to drive down costs through awarding the contract to those providers with the lowest bids. While the minister has been clear over and over that Bill 36 does not contain a requirement of competitive bidding, it is clear that the legislation is meant to achieve cost

savings by contracting out services, and does not guarantee or support in any way the public, not-for-profit foundation of our health care system.

I make the recommendation to this committee that amendments be made to the bill to ensure that privatization is not assisted by this legislation. I also question why this legislation merges not-for-profit health services and does not touch for-profit services.

Finally, as citizens of Ontario we all know that privatization does not save money in our health care system. All it does is put public money in the pockets of wealthy corporations that generate profits for their shareholders. I ask that this government do what is best for all citizens.

The Chair: Thank you. There are about six minutes left; two minutes each. We'll start with Mr. Arnott.

Mr. Arnott: Thank you for your presentation. I want you to know that over the last number of days this committee has heard from quite a number of people on Bill 36, and some of the best presentations have come from people like you. I want to congratulate you for coming forward and expressing your views today.

Mr. Gonsalves: Thank you.

The Chair: Ms. Martel.

Ms. Martel: Thank you for coming today. You didn't tell us where you work; maybe we should get that information from you. I'm assuming it's somewhere in health care.

Mr. Gonsalves: I'm actually a social worker, a family service worker for the Children's Aid Society of Toronto. I also work as chief steward for our union, CUPE Local 2316, at the Children's Aid Society of Toronto and am an active member of, and one of three representatives on, the CUPE Ontario social service workers' coordinating committee, and represent CASSs around the province.

The Chair: Mr. Ramal.

Mr. Ramal: Thank you for your presentation. I listened to it carefully. I know you have some concerns, but hopefully when we implement the LHINs, if the bill passes, all the concerns will be eliminated when you see the positives about them.

You said many different things in your presentation: You are concerned about their not being local; you are concerned about privatization. You are concerned about many different things. On what assumptions did you build your analysis to build this idea?

Mr. Gonsalves: Where did I get the information on the bill?

Mr. Ramal: Yes.

Mr. Gonsalves: Like I said, I've been spending time listening to the deputations, I have read the newspapers, and I have skimmed through the bill myself and checked the websites of unions and the media.

Mr. Ramal: When you talk about the lack of consultation, I don't know if you know or not—probably you heard us talking at many different times, since you watch the channel. You heard us on this side say many different times that before the preamble of that bill we consulted with more than 4,000 groups across Ontario to create ideas and create the bill. After that, we went on com-

mittee for—today is our sixth day—travelling the province, listening to many different people, listening to you, to many unions, to many individuals through teleconferences. We tried all avenues to engage the people of Ontario—all the stakeholders of Ontario, all the communities—to give us input. Don't you consider that consultation?

Mr. Gonsalves: I do, but sometimes it's important to consult groups of people before presenting the bill. My knowledge is that no groups were consulted prior to developing—

Mr. Ramal: We consulted with 4,000 before, and we're still in the consultation process. That's why we're listening to you. We're taking your input and the input of hundreds of other people who came before this committee to present to us.

1600

Mr. Gonsalves: I understand that. I understand that this is the process of the way bills are made into law. But what I'm saying is that you're informing me that prior to the bill coming out you consulted 4,000. Thank you for that information.

The Chair: Unless there are other questions, we thank you for your presentation.

NORTH BAY HEALTH COALITION

The Chair: I believe we are going to go to the 4:30 meeting, which is a teleconference. I believe that we already have on the line the North Bay Health Coalition: Mickey King, the chair, and Tony Morabito, the chair of the mental health division. Good afternoon. You can start your presentation any time. You have 15 minutes for the presentation and for potential questions and answers.

Mr. Tony Morabito: First of all, let me congratulate you on pronouncing my name right. My name is Tony Morabito and I'm grateful for being given this opportunity to speak to the committee today. I have many roles in health care in Ontario: as a family member, an advocate for health services and a union representative. All of these roles bring me here today.

I am the president of OPSEU Local 636. We are the workers of the former North Bay Psychiatric Hospital, now the Northeast Mental Health Centre. There are approximately 600 members in our local and we provide an array of health care services. I am also the chair of the mental health division of OPSEU. This division of OPSEU is unique, as we have members and locals both from the broader public service, where you find most hospitals and community agencies, and the Ontario public service, where the two remaining provincial psychiatric hospitals remain. At the Northeast Mental Health Centre, I work as a leisure life skills instructor. I work on a forensic unit, where I support the patients or clients of the program in meeting their work and leisure goals. I have many concerns on how the proposed legislation, Bill 36, will impact on the members of my local, on the health care providers in general and on my clients, my family and me.

When we calculate overall health care spending, Canada ranks second to the United States, due to large parts of the system that are presently being privately delivered. When private health care is calculated, Canada spends 10.7% of GDP on health, still well below the 16% the United States is forecast to spend in 2006. However, it is a cautionary statistic, particularly when we consider that the LHINs legislation opens the door to further private, for-profit delivery of health care. The fastest-growing expenditures in health care are actually outside the medicare system altogether. If we want to make health care more sustainable, the logical conclusion would be to bring more of it into the publicly funded, not-for-profit domain.

The local health integration networks are being presented as the solution to many of the difficulties Ontario is experiencing within its health care system. In fact, Ontario's health system may not be so broken as to require such a massive and costly reorganization. The real cost drivers in the system are not addressed by this reorganization. For example, pharmaceutical costs made up 16.7% of the health expenditures in 2004. Drug costs are the fastest-growing expenditure in health care, yet pharmaceuticals are left out of this structure.

Ironically, the sector repeatedly targeted by the Minister of Health is the hospital sector. It is ironic because the hospital sector has been the star performer in Ontario's health care system. They have the shortest stays in Canada, an average of 6.6 days, down from eight days in the 1990s. Ontario hospitals treat more patients on an ambulatory basis than any others in Canada and they are the most cost-efficient. Ontario also has fewer hospital beds per capita than any other province. While funding for hospitals has exceeded the inflation rate, much of that funding has been targeted to specific initiatives. When core funding is distilled, in 2004-05, most hospitals received increases of 1% to 1.8%. According to an independent March 2004 report by the Hay Group, Ontario's hospitals are more efficient than others in Canada. The Hay Group report shows that Ontario hospitals have a lower potential for finding additional savings, a reminder of the efficiency measures already taken by Ontario hospitals.

Ms. Mickey King: Hello. I'm Mickey King. I'm also an employee of the Northeast Mental Health Care, formerly the North Bay Psych. I'm a vocational specialist, and I'm also chair of the North Bay Health Coalition. I'm here today for many reasons, but the main reason is that I'm one of the people who actually works in the system that we already have. I see the results of the cuts and I fear for what you're doing. If you could walk a mile in the shoes of the people we work with, maybe you'd understand that this isn't such a good idea.

While the local health integration networks have been touted as a solution to the integration problems within the system, key parts of the system remain outside the model. Physicians are left outside the system, despite their role as gatekeepers. Ambulance is left out, despite problems interfacing with hospitals. Public health is left out,

despite the lessons learned from SARS. Hospital labs are in; private labs are out. Psychiatric hospitals run directly by the ministry will be out; divested ones will be in.

The cleaving of the health care system in fact creates more disconnects with certain sectors, like mental health, than presently exist. I count myself fortunate that I have a family physician, but for how long? My clients are not so fortunate. Those who do not have a family doctor use the walk-in clinics, emergency rooms and, when all else fails, a physician contracted by the mental health services for in-patients. They have no chart, no consistency, no preventive health care. By leaving physicians out of the LHINs, the needs of a very vulnerable group of users of the health care system are not being met.

Commercial interests reduce sharing of best practices. By going to a purchase provider model, like the CCACs, there will be incentive not to share best practices given to facilities within a sector that may face competition. My fear is that the integrated services that are common in mental health will be carved off.

Outpatient support teams, such as ACTTs, case managements and intensive community treatments, will no longer be able to provide the range of services that they now do. Will the interests of cost-efficiency mean that these teams will not have dedicated rec specialists, voc specialists, trained professionals who support, educate, mentor and hand-hold when necessary? That's what I do every day, my job.

The emphasis on making the system more sustainable suggests the public are about to pay a price for this so-called sustainability. The often cited example is of a number of hospitals transferring cataract surgeries to a single factory-style clinic, yet when it is suggested that other services could follow the same route, the government surprisingly calls its critics fearmongers.

Under fiscal pressure from the government, the LHINs could very well rationalize many health services under the integration plans, forcing patients to travel hundreds of kilometres for services they presently receive in their local communities. While this may be efficient from a delivery standpoint, it is not efficient from a user standpoint. Who pays for flights, hotels, time off work, to assist patients to travel to distant cities for treatment? For those who cannot afford these substantial expenses, are we creating a two-tier system? What is the difference between charging user fees and creating conditions whereby access to health care is dependent on sustainable personal expense.

The clients that I support cannot afford to travel outside of their home community for treatment. Just because they have a serious and persistent mental illness, that doesn't exclude them from suffering from other health issues. Actually, they are more likely to suffer from other health issues. The medications often lead to weight gain, increase in type 2 diabetes, high cholesterol, heart conditions and other health concerns related to obesity. Many of the medications that are used to control the active symptoms of their mental illness need to have kidney and liver functions closely monitored monthly. They will need access to specialists in their lives, and if that access

is not in their home community, who will get them to and from appointments? Who will provide the after-procedure support? The family physician? Don't forget, they don't have one, because you can't get them one. Over a number of years, the former North Bay Psychiatric Hospital has been actively recruiting psychiatrists and many more professional disciplines, but with little or no success.

Permanent instability: Across Ontario health care, users are likely to experience more and more service transfers under the LHINs. The LHINs are not a one-time restructuring, but rather, a process for continued amalgamations, transfers and even the winding up of certain services. This is permanent instability within our system. While there is some limited protection for workers under the Public Sector Labour Relations Transition Act, which Bill 36 proposes to amend, it is cold comfort to those who will be forced to choose between their community and their job. Workers are not always as portable as the government would like to believe. Two-income families are often faced with a dilemma when the workplace for one is suddenly shifted to a location hundreds of kilometres away. In mental health we have been down this road, and having lived it, we can tell you it's not pleasant.

1610

North Bay Psychiatric Hospital was divested in 2005, with another tier-2 divestment coming in 2006—maybe even tier-3, we've heard from our management. Yes, we had a choice when we were divested, but if we didn't accept the employment with the receiving hospital, then we were unemployed. Some choice. It doesn't take a rocket scientist.

With the recent media attention on the divestment of ACTT teams in southwestern Ontario from St. Joe's regional mental health centre, the former London Psych and St. Thomas Psych, to the community agencies in the Windsor area, our members are scared. Do they have to do this again: accept job offers from employers they never wanted to work for or face unemployment? With this legislation they don't even have the rights they did the first time they were sold off, or, in a polite way to say it, divested.

The impact on the client has never been fully explored. Fortunately, most of them kept the same providers. However, the providers who did their jobs changed and some of the supports and services that were previously available to our clients and their families changed. There is no more patient counsel or family resources on the site of the centre.

I'm aware that the hospital is facing challenges in recruiting all the professionals it would like. I fail to see how this legislation would be of assistance with this challenge. Who wants to come and work in health care in Ontario when you have no guarantee of employment or working conditions?

We cannot understand why non-clinical services are being targeted by the government. Under section 33 of the bill, dietary and building maintenance are inherent parts of the health care system. Other health systems

have made these services the focus of privatization and restraint, creating more hospital-borne infections and increasing the likelihood of the transmission of viruses in the health care environment. It is another case where the government's idea of integration is contrary to the good functioning of the health system.

In the hospital I work in, the non-clinical staff are just as important as the clinical staff. Our non-clinical staff are highly trained and absolutely necessary. The clients rely on them to assist in keeping them safe. I rely on them to keep me safe. They interact with patients on the floor in a way that is difficult for clinical staff to really see what is going on. I'm seeking a definition of non-clinical services. Is it dietary, maintenance and house-keeping? Is it the staff educational department? Is it the secretarial pool that types notes and letters, clinical notes and psychiatric notes? Is it the practice leaders who support our work or the managers who don't directly look after clients? All of these services are essential to the client's care team and to the health care workers who provide care to the client.

If the McGuinty government truly wants to devolve decision-making to the community, why would it not set up elected boards like school boards?

Lacking in the LHINs legislation is any real HR strategy. While the PSLRTA rules do provide a forum for unions to battle out representation issues, the whole process is going to create retention and recruitment problems. Human resources plans need to be negotiated and include layoff as a last resort, measures to avoid layoff, voluntary exit options, early retirement options, pension bridging and retaining options. A transitional fund should be put into place and a health service training and adjustment panel should be convened.

I do have suggestions on what is needed for a health care system, and they are:

Front-line workers and unions need to be consulted in the development of LHINs.

Health care needs to be fully portable and equitable so that everyone in Ontario has access to the same minimal level of services, no matter where they live.

LHINs must comply with the Canada Health Act and the Romanow commission and their role should be to provide planning advice to the Ministry of Health.

The health care sector must not be compromised for for-profit services.

No competitive bidding on health care should be permitted in any LHIN.

No further fragmentation of services but consolidation to improve services.

The Chair: Ms. King, can you conclude, please?

Ms. King: Okay. The LHINs must be accountable to the citizens and the minister.

Successor rights need to be restored to all members who work in this field, especially the Ontario public service.

Front-line staff, their bargaining agent and collective agreements must follow the work in any restructuring, transfer or sale of business.

Employment stability: No layoffs and a mandatory, comparable job offer.

Seniority needs to be recognized, seniority needs to be dovetailed and voluntary exit options are necessary.

Employees' rights under the Ontario Labour Relations Act, the Employment Standards Act and pay equity will remain intact.

Human resources plans for affected workers must be negotiated with health care unions.

You need to think about what you're doing to the people who work in your community, in your province, and the people who receive the services.

The Chair: Thank you very much for both your presentations. There is no time for questions. We thank you very much for your presentation. Bye-bye.

There is only one other presentation left; that's the 4:45. We called them. I'm told that they are on their way, but they're not here yet. It should be any moment. That's the Association for Healthcare Philanthropy. My suggestion is that we hang around here. The moment they come, we'll hear them and that will be all. There have been a few cancellations today, as you can see from your list. Do we all agree? Thank you.

The committee recessed from 1616 to 1630.

ASSOCIATION FOR HEALTHCARE PHILANTHROPY

The Chair: We will start the next presentation; I believe it's Pearl Veenema. Would you please have a seat? You can start whenever you're ready. Your presentation is the last one for the day. We are happy that you're here. Thank you for coming half an hour earlier to assist us.

Ms. Pearl Veenema: It was fortuitous that I was just down the street and able to do so.

First, I'd like to introduce myself as the chair-elect of the Association for Healthcare Philanthropy, or AHP. I would also like to introduce Alex Maltas. Alex is with Fraser Milner Casgrain. Being an international organization, and given the context of the bill, we wanted to be properly informed and therefore have been working with Mr. Maltas.

AHP Canada is part of an international organization of health care fundraising executives and health care institutions that is dedicated solely to the advancement of health care through philanthropy. Our association represents 390 health care charities nationwide—that's in Canada—the majority of which are in Ontario. We very much appreciate the opportunity to make some remarks and to share some of the issues with respect to this bill, and we thank you for that opportunity.

There are specifically two aspects of the bill that we would like to address. One relates to section 30, which allows the minister or a local health integration network, or LHIN, to order a health service provider to transfer charitable property it holds. The second relates to subsection 50(11), which amends a subsection of the Public Hospitals Act to allow the minister, by regulation, to

require hospital foundations to provide financial reports and returns to the LHINs.

As mentioned earlier, section 30 allows the minister or LHIN to make an order directing a health service provider to transfer charitable property that it holds to a transferee. We believe that donors play an important role in health care today, and that charitable gifts are most vital to our organizations. Donors do make their contributions, and today are choosing very carefully, given the number and growth of charities across the country, the areas they would like to support.

AHP Canada is deeply concerned that giving the minister or LHINs the power to transfer charitable gifts donated from one organization to another directly contradicts the fundamental right of donors to determine where their donations are directed. We are concerned that the provisions of the bill do not allow donors or health care providers to have input to, or perhaps be privy to, consultations regarding transfers of charitable property. We believe that this function is perhaps best left to the courts. The courts currently have jurisdiction to transfer charitable property in circumstances where it is no longer possible for the terms of the original donation to be fully discharged. We also believe that the courts are well placed to perform this function, because they do so from an impartial point of view, have expertise in making such decisions and, importantly, allow stakeholders to offer input as to when or how charitable property may be transferred.

We're very much concerned that this section may discourage donations to health care providers and organizations. Gifts, as you know, are often based on a desire to make a difference at the hospital of a donor's choice. If donors feel that the minister or the LHIN could perhaps set aside their original charitable intention and move their philanthropic gift to another facility or program, donors may choose to direct their charitable contributions to non-health-care-related organizations, a decision that will not benefit but perhaps hurt our health care system by removing an important source of funding that institutions rely on.

AHP Canada proposes that section 30 be deleted from the bill and that decisions regarding the transfer of charitable property be left to the courts.

Subsection 50(11) amends subsection 32(4) of the Public Hospitals Act, allowing the minister, by regulation, to require hospital subsidiaries and foundations to provide financial reports and returns to LHINs. We understand that the minister previously enacted regulations under this section in 1996. AHP's understanding is that at that time hospital foundations and other health care organizations expressed concern over the legal validity of these regulations. Concerns were also expressed regarding the possibility that financial information obtained from hospital foundations might be used to reduce the operational funding the institutions receive from the government, and perhaps that there would be an expectation that hospital foundations cover the shortfall.

We understand that in 1998, after discussions and negotiations with all parties involved, the minister

decided it was best to revoke the regulations. We also understand that the minister agreed not to enact any further regulations. So it leaves us uncertain today as to why Bill 36 purports to broaden the scope of a provision that has really not been in use for the past eight years and that it was previously agreed not be used, and we are actually seeking clarification on the purpose and intent of these amendments.

I'd also like to say that this is not a concern from an accountability point of view. Foundations do file their public financial statements, and these are widely available through the T3010s we are all required to file. So this isn't about accountability or the lack of it, but really to address why and to ask for clarification on this, concerned that at this particular time, as our institutions depend so much on philanthropy, there may be some negative consequences.

Lastly, we share the concerns that were expressed in 1996 regarding the requirement of financial disclosure. Particularly, at this time, AHP is concerned that our hospital foundations are being called on to provide significant support for research programs and capital projects, and clearly don't wish—and we know you share that concern—that at any time that source of additional and generous public funding not be available for these key projects.

AHP proposes that the reference to “hospital foundation” be removed from Bill 36 and from subsection 32(4) of the Public Hospitals Act.

We believe that a flourishing philanthropic community is in the best interests of our country. We want to continue to foster an environment where donors are encouraged to give to the health care organization of their choice. We want to ensure, as we know you do too, donors' comfort in knowing that their gifts will be directed to the purposes for which they gave them originally.

We certainly feel that charitable support is more and more critical to health care institutions. We know that, in particular, it is very critical to the research agenda for our province. In closing, on behalf of the Association of Healthcare Philanthropy, we know that you support and encourage charitable activity, and we are hoping that you would consider amendments deleting section 30 from Bill 36 and deleting the reference to “hospital foundations” from subsection 50(11) of Bill 36 and subsection 32(4) of the Public Hospitals Act.

The Chair: Thank you, Madame Veenema. There's about five minutes left. Ms. Wynne?

Ms. Wynne: Thank you very much for coming today. A couple of things: First, we have heard your second recommendation from a couple of organizations, so it's in the works in terms of a recommendation that has come to us. Have you been in conversation with the ministry about it? Have you been in any dialogue with the ministry or the minister's office about this?

Ms. Veenema: With respect specifically to the requirement on the filing?

Ms. Wynne: Yes, subsection 50(11).

Ms. Veenema: In fact, one of the things we did try to do first—it was just from a scheduling point of view—was meet with the Deputy Minister of Health who was involved back in the late 1990s for that clarification. Regrettably, scheduling did not permit, and we felt we could not lose the opportunity to make our concerns known to this committee on behalf of health care charities.

1640

Ms. Wynne: That's good to know. Thank you.

The second thing is, in section 30, this subsection (2)—I'm just going to read it. You've expressed a concern about the specified purpose that a donation may have been intended for. Subsection (2) says, "If a will, deed or other document by which a gift, trust, bequest, devise or grant mentioned in subsection (1) is made indicates that the property being transferred is to be used for a specified purpose, the transferee shall use it for the specified purpose." Can you comment on that section? Because that seems to put some of the protection that you're looking for in place.

Ms. Veenema: I guess there are two things. One that I briefly mentioned is how that happens. Having been part of a hospital and foundation merger most recently—Sunnybrook, Women's College and the Orthopaedic and Arthritic—and having had conversations with donors in particular—and I'll speak from the experience that I had the closest, the Orthopaedic and Arthritic: Although the musculoskeletal program continues as a priority program within Sunnybrook and Women's, the concern that the donors had as we approached them about the amalgamation and so on was what kind of guarantee they would have with respect to the use of and the original purpose of the gift that they gave. They wanted to be part of that dialogue. As it turns out, that certainly helped to facilitate donor comfort, but it took a substantial amount of time and process to be able to engage the donor community to feel a comfort level.

I won't go into other experiences related to that particular merger, but I will share another that may be familiar to members around this table, and that is related to the time that the Wellesley Hospital closed and programs and services were transferred to St. Michael's Hospital. A donor whose family had invested very significantly in the maternal program and built a brand new birthing facility—and then, of course, the institution over time was slated for decommissioning. That conversation became a real challenge for fundraisers, or that feeling that the donor has: that there isn't enough protection or respect for what was the original purpose of the gift.

Ms. Wynne: Can I ask one more question on that?

The Chair: Yes, of course.

Ms. Wynne: Do you think the bill should be silent, then, on that—because you're saying to delete that section altogether—or should we be amending it to set in place a process or a framework that would be more respectful?

Ms. Veenema: The key thought that we had was that there is due process for that; in the event that there is integration, it is not required to be in this particular bill.

Ms. Wynne: So that just puts everything into the courts, is what you're saying.

Mr. Alexandre Maltas: I think a sensible compromise on this specific issue is that perhaps the minister or a LHIN could seek judicial approval before property was transferred. I think that our association, along with other stakeholders, would probably be interested in developing criteria or guidelines that would govern the acceptable conditions under which property could be transferred from one charity to another.

We understand the minister's concern here, the government's concern why this provision is in the legislation. But at the same time, we feel that by providing this judicial review of the minister's decision, or simply having the minister seek judicial approval, provides a greater level of comfort to donors that there is some judicial accountability, that there is a review of the decision. We think, going forward, that that could be a possible compromise between leaving everything to the courts and leaving things to the minister. We think that could be a possible compromise.

Ms. Wynne: Thank you.

The Chair: Before I recognize Mr. Arnott, did I understand you correctly that you feel comfortable with the courts making the decision? Because the courts in the past have ruled in favour of the donors. Is that a fair conclusion?

Ms. Veenema: The impartial view, in our opinion, looks at what the original intent of the gift is and can act as a trust on behalf of the donor as there is consideration for the organizations that would perhaps be beneficiaries or recipients of those gifts.

The Chair: I was involved in a case, and that's exactly what happened: the court ruled in favour of the donors because they felt that their intent should stay the same. As long as the intent is still the same, even if there is a change, it cannot change significantly to affect the original intent of the donations. The court ruled in favour of the donor in a public situation.

Ms. Veenema: My experience has been, having been through a foundation merger, that with conversation and consultation there is the opportunity to talk; that, in the event that you couldn't 100% follow the intent or the original intent, it's done in the spirit of the gift.

The Chair: Exactly. Thank you. Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. When these hearings commenced this afternoon at 1 o'clock, we heard from the Council of Academic Hospitals of Ontario. They expressed concern about this provision in Bill 36 which gives the minister the power to require hospital foundations to provide financial reports to LHINs and asking for clarification and amendment.

I expressed my reservations about that particular section of the bill and suggested my explanation as to why the minister was seeking this power and my concern about it. In response, the chief government whip, the

member for Brant, said I was completely out to lunch, essentially, and was overstating the case dramatically.

Unfortunately he's not here at the moment to hear your presentation, because I think you've again expressed the concern very clearly. The government has acknowledged they're aware of the concern. Now the litmus test is what's going to happen with the amendments. There's an opportunity for us to amend this bill, as you well know. I can't commit our party to an amendment at this point in time, but certainly my own position is that this needs to be clarified. On behalf of the Progressive Conservative Party, we understand the concern. I hope that we will see the government members, when the bill finally does come back for clause-by-clause, support the kinds of amendments you need to clarify this issue to your satisfaction, in the interests of all the hospitals in Ontario and all the hospital foundations and their supporters.

Ms. Veenema: We very much appreciate that. Also, we're very much looking forward to the upcoming budget and the elimination of capital gains. We know our donors are going to be looking for that, and those who

are waiting to see, to make a very significant investment in health.

The Chair: That's another topic, Ms. Veenema. I understand from the government whip that she will try to arrange—

Ms. Wynne: Yes. If you're still interested in meeting with ministry officials, we can try to make that happen.

Ms. Veenema: Thank you.

The Chair: The clause-by-clause will take place on the 15th, so there is that space. The 15th of this month, right?

Interjection.

The Chair: February 13. I'm sorry. If you can meet prior to that date, February 13, I think there will be plenty of opportunity to look into what you're raising and try to deal with it, if possible.

We thank you for your presentation. We thank all of you for being here today.

We'll resume tomorrow at 9 o'clock, same place. Have a nice day.

The committee adjourned at 1648.

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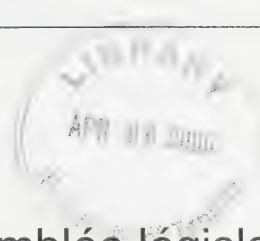
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Deuxième session, 38^e législature

Official Report of Debates (Hansard)

Wednesday 8 February 2006

Journal des débats (Hansard)

Mercredi 8 février 2006

Standing committee on social policy

Local Health System
Integration Act, 2006

Comité permanent de la politique sociale

Loi de 2006 sur l'intégration
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Wednesday 8 February 2006

Mercredi 8 février 2006

*The committee met at 0902 in committee room 151.*LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

The Chair (Mr. Mario G. Racco): Good morning and welcome to our final deputation day on Bill 36.

ENVIRONMENTAL HEALTH CLINIC,
SUNNYBROOK AND WOMEN'S COLLEGE
HEALTH SCIENCES CENTRE

The Chair: The first deputation for the morning is from the Environmental Health Clinic; Dr. Alison Bested. There are 15 minutes for your deputation and potential questions.

Dr. Alison Bested: Good morning, Mr. Chair and committee members. My name is Dr. Alison Bested. I'm one of the physicians working part-time with the Environmental Health Clinic at the Women's College Ambulatory Care Centre, which I will refer to as Women's College in the future. I am here at the request of the clinic's patient consumer advisers Ms. Eleanor Johnston, representing the Environmental Hypersensitivity Association of Ontario to my right, and also Ms. Audrey MacKenzie, representing the Myalgic Encephalomyelitis Association of Ontario. She sends her regrets; she's ill today.

Thank you for allowing us the opportunity to voice concerns about how the introduction of Bill 36 will negatively impact upon the Environmental Health Clinic and other innovative provincial ministry programs since they are left out of the LHIN model.

We represent the 1.5% of the people of Ontario who suffer from chronic fatigue syndrome or myalgic encephalomyelitis, multiple chemical sensitivities and fibromyalgia. How many of the committee members had heard about these very common illnesses before the presentation today?

The Chair: At least two—three.

Dr. Bested: Very good. Enclosed is background information about the Environmental Health Clinic, since this innovative provincial clinic is probably unknown to you. Following the presentation I will answer any questions the committee may have.

I hope to make clear to you today how the Environmental Health Clinic is left out of the LHIN model, why it is vitally important for the patients in Ontario to be included in the new model of health care for the province, and how this may be accomplished.

In response to emerging patient needs in the 1980s and the recommendations of the 1985 Thomson Report on Environmental Hypersensitivity Disorders, the Ministry of Health pioneered the creation of the Environmental Health Clinic in 1996. It is currently located in the Women's College Ambulatory Care Centre of Sunnybrook and Women's College Health Sciences Centre. The Environmental Health Clinic and Environmental Hypersensitivity Research Unit, which is the research arm of the clinic, resulted from the vision of the Ministry of Health as examples of unique, successful incubator programs in the province. They have been pioneers in developing ground-breaking research, diagnostic criteria, education, health promotion, clinical coping tools and strategies to help patients cope with these emerging, complex, chronic, environmentally linked illnesses.

The Environmental Health Clinic is the only government-funded, academically affiliated, provincially mandated clinic in the province providing limited services for the adults with myalgic encephalomyelitis or chronic fatigue syndrome, multiple chemical sensitivity, fibromyalgia and other environmentally linked illnesses. These are newly recognized chronic, complex medical conditions that can result in patients becoming severely disabled and unable to sustain any permanent employment. These conditions are extremely common, and early treatment can prevent worsening of symptoms and avoid huge costs to the Ontario health care system and to medical disabilities programs such as ODSP as a result of patients becoming severely disabled. The prevalence of ME, MCS, and FM equals diabetes at approximately 1% to 2% of the people of Ontario, according to the 2000-01 Canadian Community Health Survey.

The impact of the environment on health from ongoing low-grade environmental exposures such as second-hand smoke or indoor air pollution is just now being appreciated. Yet the Environmental Health Clinic, the only provincial program, has less than one full-time

doctor-equivalent on staff for the entire province of Ontario. The clinic has an eight-month waiting list, and is only funded for one comprehensive assessment and one follow-up visit, for adults only.

The Environmental Health Clinic provides a limited patient-centred consultation service for a vulnerable group of patients, mostly women, many of whom have a high burden of ill health and high use of the health care system, including CCAC or home care, because of their high degree of functional impairment and disability. They have considerable difficulty accessing appropriate health care, social systems and accommodation in housing, schools and workplaces if they can still continue to work.

The EHC needs to respond to patients' needs in Ontario, and become an ongoing treatment clinic that provides ongoing care for both adults and children in an academic research setting.

These illnesses are called the orphaned illnesses. These patients are so complex and time-consuming that they often can't get a family doctor in Ontario. Nobody wants these patients in the current 10-minute booking schedule model; they simply take up too much time. As a result, these patients are denied access to health care in Ontario on an ongoing basis due to having newly, poorly understood illnesses that are very complex and take up a lot of physicians' time.

The clinic's integrative model is very different from the usual hospital or primary health care model. A part-time team of physicians, family physicians and medical specialists, myself, a psychologist, nurse educator-coordinator, a program manager and community outreach coordinator together, in a team approach, try to help support this community of patients in the rapidly emerging area of environmental health.

The Environmental Health Clinic also does population health and health promotion in collaboration with community partners, extensive networking, educational seminars, plus educating medical students, nursing students and physicians in the community, both family physicians and specialists.

Currently, the clinic is a provincially funded clinic with base funding that has not been increased, even with the cost of living, since 1998. As a result, the clinic has had more to do as it has become established, and has had less money to do its work, as the hospital employees have had raises with no mechanism to increase its budget.

Women's College, contending with other pressing local priorities and budget pressures, decided that the clinic was not a priority program and did not ask the ministry for additional funding, despite the need for the expansion to meet the needs of patients in Ontario.

In the spring of 2004, in response to ongoing budget problems in health care, and after doing a strategic focusing, Women's College decided that the Environmental Health Clinic did not fit Women's College's strategic plan and the Environmental Health Clinic should find a new home.

The Environmental Health Clinic is a provincially mandated clinic that is overseen by a hospital that is

mandated to deal with local health issues. Does this sound familiar? This creates an obvious conflict in outlook of patient care.

The ministry stated to patient stakeholders that the Environmental Health Clinic must continue and be transferred with its base funding to follow the program wherever it relocates. Searching for a new home has been difficult and worrisome to staff, patients and community partners.

At this point, we are guardedly hopeful that when Women's College is de-linked from Sunnybrook at the beginning of April, the incoming board will review its decision and agree to help keep the Environmental Health Clinic as part of their new focus. We will still need to address the need for increased funding for the Environmental Health Clinic and the need for at least one in-patient hospital bed in Ontario for patients who are critically ill and need to be hospitalized. There are currently no hospital beds for these patients with special needs.

The LHIN process, which is dividing the province into 14 LHINs, has a number of potential benefits, including opportunities to improve local co-operation, networking and possible integration of services in some areas. The LHINs will be expected to set priorities based on local needs and opportunities, and to stretch limited resources to best meet those pressing local needs and local priorities. Competition for priority status and funding will be quite intense.

Provincially mandated and funded programs such as the Environmental Health Clinic are totally left out in this LHIN model currently. There's no mechanism to expand the clinic to all 14 LHINs, and it is impossible to stretch one physician-equivalent and supportive staff into 14 different locations. In the LHIN model, there is no mechanism to fund the Environmental Health Clinic on an ongoing basis or to review the funding on a periodic basis. The Environmental Health Clinic budget is overseen by a hospital with a local mandate, which to date has viewed the clinic, with its provincial mandate, as a low priority.

0910

The new health care system needs to include provisions so that innovative ideas can be incubated, even if they are not local priorities or priorities within a hospital's strategic plan. The system cannot leave to chance that one of the 14 LHINs would do all necessary pioneering work in such areas. Equity requires that information about such innovative ideas and access to promising treatments are available to all patients throughout the province.

The idea that tobacco smoke could cause cancer in cigarette smokers and also that second-hand smoke could cause cancer took many years to gain acceptance. Had the innovative idea that smoking was related to cancer been studied earlier and appropriate action taken, the health and quality of life of many people would have been greatly improved, lives could have been saved and thousands and millions of health care dollars saved.

In a LHIN that includes an innovative program such as the Environmental Health Clinic that serves the whole province, local, financial or other pressures could result in a decision to eliminate the program and its benefits for the entire province. Such a decision would leave a major gap in services to patients province-wide, without the rest of the province having any input. Clearly, this would not be in the best public interest: Scarce expertise and years of pioneering work would be lost.

In our opinion, Bill 36 should include some explicit provisions that the ministry retain the responsibility and powers, duties or functions to supervise and support work in some innovative areas such as the Environmental Health Clinic. This would still be in keeping with the ministry's wanting to devolve many powers to the LHINs while asserting itself at a more strategic level.

Our experiences illustrate why such provisions would be important to the survival of some innovative programs. When the joint clinical and research program was being established, a ministry-appointed clinical research advisory board or CRAB provided advice to the program and recommendations to the ministry, including funding. It was this board that recommended that Women's College hospital be asked to be this provincially mandated clinic's host hospital. Later, when the advisory board was discontinued, all contact with the ministry was through Women's College. The clinic has a six- to eight-month waiting list. The program urgently needs to be expanded to provide ongoing treatment to adults and to offer services to children with these complex and often disabling illnesses. It needs funding for an in-patient hospital care setting.

The Environmental Health Clinic's provincially mandated focus on these emerging illnesses, its unusual integration of both patient-centred and population health activities, and its collapsing budget that has effectively decreased since 1998 are reasons for the minister to re-establish a ministry-appointed clinical research advisory board or CRAB to provide advice to the program and recommendations on issues, including funding, to the ministry. This type of mechanism would ensure that innovative programs such as the Environmental Health Clinic will continue in the Ontario health care system as it is reformed and modernized.

Innovation is important to this government. As Premier McGuinty, who is Minister of Research and Innovation, has said, "If you want a culture of innovation, we need to support the risk-takers, the dreamers and the doers," such as the Environmental Health Clinic. The ministry needs to have mechanisms to ensure that innovative or incubator programs such as the Environmental Health Clinic can develop and not be inadvertently squeezed out by processes being used to modernize the Ontario health care system.

We urge you to include in Bill 36 new, specific provisions to support innovative programs such as the Environmental Health Clinic.

The Chair: Thank you for your presentation. There is about a minute left; 30 seconds each.

Mr. Ted Arnott (Waterloo-Wellington): Thanks very much for your presentation. We really appreciate your advice and suggestions. We have heard from a number of what I would characterize as highly specialized health service organizations like yours over the past few days. I think there is a sense of anxiety out there as to whether these services will continue after the passage of Bill 36 and its implementation. Are you confident that the important services to patients, and to your broader clientele in the medical field too, will continue after the passage of Bill 36 and its implementation?

Dr. Bested: We have been reassured that the clinic's current budget will be continued. The concern is that in its current state, it's inadequate: Children are not being treated, and there is no in-patient hospital care for this patient population, which represents 1% to 2% of people in Ontario.

Mr. Arnott: There's a lot more to do, and you've made a good case.

The Chair: Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): Thank you very much for being here; I've met with Ms. Johnston.

In the conversation you're having right now with Women's College, have you also talked to them about the women's health institute and the possibilities of a linkage there?

Secondly, you're saying that you wouldn't like to see the Environmental Health Clinic's mandate included in the accountability agreement of one LHIN but you'd rather see the ministry retain control. Is that accurate? It could be that an accountability agreement for the area that Women's College is in could have as part of its mandate to encourage and make sure that this work continues to be done, but that's not what you're looking for.

Dr. Bested: I think there is currently nothing specific in Bill 36, so this needs to be addressed. Because this is a new, emerging area, it would be preferable, until there is enough available support that it be present in each LHIN, that it be part of a global, overall perspective of the ministry. I think that would be the preferable position, because there's only one physician equivalent for all of Ontario.

Ms. Wynne: Right. So when patients come to the clinic, they see a practitioner.

Dr. Bested: Right. They have a one-time assessment and a one-time follow-up. There's no ongoing treatment.

Ms. Wynne: Okay. Thank you very much.

The Chair: Thank you for your presentation.

UNION OF ONTARIO INDIANS ANISHINABEK HEALTH COMMISSION

The Chair: The next presentation is from the Union of Ontario Indians: John Beaucage, grand council chief of the Anishinabek Nation. Good morning.

Grand Council Chief John Beaucage: I'd like to say good morning to everybody and then just make a special

acknowledgement to Norm Miller, the MPP for my riding, and also to Peter Fonseca, who is on the Smoke-Free Ontario committee, on which I sit as well.

I'd like to begin this joint presentation of the Union of Ontario Indians and the Anishinabek Health Commission with my co-presenter, Elder Merle Assance-Beedie of the Beausoleil First Nation. Elder Assance-Beedie will open our discussion with a teaching of the Anishinabek *mno-maadzowin*, or living a good way of life. That's what we as Anishinabe people are acknowledging: the responsibilities and obligations of health and healing. Is that okay with the committee members?

Ms. Merle Assance-Beedie: Good morning. I'm going to begin by doing what we do as a tradition, and that is to give you my spirit name, which is Waas No De Kwe, which means "northern lights woman." I'm of the Otter Clan, and Christian Island is my home community.

It's a pleasure to be here and to address such an important gathering. I would like to give you a very brief history of the *mno-maadzowin*, which translates to "a good life," that our people enjoyed prior to contact. In fact, one of the famous research institutions in Canada acknowledges that the First Nations enjoyed an ideal way of life prior to contact. As a teaching, I'm going to give you a short history of what *mno-maadzowin* is.

From zero to six, a child is given what is called the good life. From the time he's zero to six or seven, he's given a tremendous amount of nurturing and love and care, which prepares him for the rest of his life. We haven't enjoyed that kind of experience for some time, and that is what we would like back for our children.

The next stage of life is the fast life stage, where the children can't do anything fast enough. Those of you who have children and grandchildren will recognize that from the time a child is seven until they're 14, they can't move fast enough. We're always chasing after them, and everything they do is so fast.

0920

The seven-stages-of-life teaching takes an entire seven days to recall and to pass on to our students and our people. So I'll just leave it at that. I'll just give you the two stages of life briefly, because it takes an entire day to go through each stage. The seven-stages-of-life teaching was part of our ongoing, day-by-day way of doing things prior to contact, and we knew no other way of life than the one we were born into, which was a good life. Everything that we did was with respect, with truth, with humility, with love, with kindness—all of those seven grandfather teachings that each and every one of us hear about daily from First Nations people. We live that way of life.

Any word in our language that has the word "win" at the end of it translates to "a way of life." *Mndenamowin* is "respect," so we had a respectful way of life. *Sahgidiwin*, "love" in our lives; *devwayowin*, "truth," came from the heart, and that was a way of life prior to contact.

Mno-maadzowin means a returning to that kind of life for us. That is what we are working towards. I wish I

could explain all of this in our own language to you so you could understand, because in our language those teachings are so powerful, and they are so good. I will leave it at that. I thank you very much for listening.

The Chair: Thank you.

Grand Council Chief Beaucage: Chi meegwetch, Elder Merle.

My name is John Beaucage. I'm the Grand Council Chief of the Anishinabek Nation. I have been entrusted to serve the 43 chiefs of the Ojibway, Pottawatomi, Odawa, Delaware, Chippewa, Algonquin and Mississauga First Nations that comprise the Anishinabek Nation.

The Anishinabek Nation incorporated the Union of Ontario Indians as its secretariat in 1949. The UOI is a political advocate for 43 member First Nations across Ontario. The Union of Ontario Indians is the oldest political organization in Ontario and can trace its roots back to the Confederacy of Three Fires, which existed long before European contact. The peoples of the Anishinabek Nation have governed themselves in this manner as a confederacy since pre-contact times. Today, the Union of Ontario Indians receives its political mandate from the 43 chiefs at regular and special assemblies of the Anishinabek Grand Council.

The Anishinabek territory encompasses the entire Great Lakes area from the eastern watershed of Lake Huron, near present-day Ottawa and Peterborough, westward to the northwest shores of Lake Superior and through the south-central part of Ontario to the base of Lake Huron at Sarnia and London. The Anishinabek Nation territory is the traditional homeland of 35% of the total First Nation population in Ontario today. I would like to acknowledge the Mississaugas of New Credit, on whose territory we stand before you today.

We have a number of significant concerns with regard to Bill 36, the Local Health Systems Integration Act. Certainly, on the surface, the integration and reorganization of health services is a positive and sensible approach for Ontario. It will place significant decision-making power for health at the community level and ensure that local service delivery remains in local hands. It will go a long way to ensure that health resources and funding meet community priorities. However, there are some very real concerns that First Nation programs and services and the unique needs of First Nations communities will be lost in this process.

Yesterday, we met with the Minister of Health and Long-Term Care, and he proposed some amendments to Bill 36 that will speak to the engagement of First Nation communities at the LHINs level. Further, he spoke to a new government-to-government process with First Nations in Ontario. The minister and the legislation speak of community engagement, but will that engagement truly meet the needs of our people? Will these amendments meet the minimum standards for consultation and accommodation of First Nations' interests that have been brought down by the Supreme Court of Canada? Do these amendments respect the aboriginal, treaty and inherent rights of First Nations people in Ontario?

The Supreme Court of Canada has consistently upheld First Nations' right to be consulted and accommodated on issues involving aboriginal rights in the following case law:

- R. v. Sparrow*, 1990;
- Delgamuukw v. British Columbia*, 1997;
- Haida Nation v. British Columbia*, 2004;
- Taku River Tlingit First Nation v. British Columbia*, 2004; and
- Mikisew Cree First Nation v. Canada*, 2005.

The Supreme Court has decisively confirmed the duty to consult and even accommodate aboriginal communities even where aboriginal rights and title are not yet proven.

The government of Ontario has yet to adequately respond to the Supreme Court decisions, nor has it developed a position on consultation and accommodation in dealing with aboriginal people in Ontario. The Supreme Court advocates a jointly developed process of consultation in dealing with aboriginal issues. To proceed with implementation of the Local Health Systems Integration Act without adherence to Supreme Court requirements could leave this legislation open to a constitutional challenge based on *Haida Nation-Taku River*.

We recommend the following: that the committee on social policy recommend that a comprehensive review occur to study the legal duty to consult First Nations, including requirements under the Supreme Court and how they may affect the Local Health Systems Integration Act; that the government of Ontario and Ontario First Nations jointly develop policies and guidelines to meet the minimum requirement for consultation and accommodation of First Nations' interests.

It is our hope that the provincial government will work with First Nations in a truly collaborative manner to fulfill their constitutional duties to consult with and accommodate First Nations, in order to improve the health status of First Nations members residing both on and away from their reserves.

Here are a few more questions:

- Will the 14 LHINs across Ontario understand our First Nation communities and health concerns?
- Will they understand traditional healing or the healing value of the sweat lodge or naturopathic remedies?
- Do they understand why the suicide rate is almost six times higher in First Nation communities than in mainstream society?
- Do they understand the concept of intergenerational impacts of residential school abuse?
- Have they lived in an overcrowded home, infested with mould and undrinkable water?

These are questions that cannot be answered by the Legislature or by this committee. Only First Nations have the answers to these questions, and First Nations need to be a significant part of the solution to improve First Nations' health in Ontario. After all, that is the goal of this bill: to put decision-making power for health at the community level. First Nations expect nothing less.

I'm here to urge you to protect First Nations' interests in the Ontario health care system. We need to ensure that our priorities continue to be decided upon by our governments, not a board of non-native people who cannot possibly understand our people, our health concerns or our way of life.

In recommending a legislative exemption and non-derogation clause, our intent is to provide the Ontario Legislative Assembly with an opportunity to maintain the status quo for First Nations health programs and services and prevent a further decline in the health status of First Nations. The acceptance of the First Nations' amendments to the legislation—exemption and non-derogation—provides the standing committee on social policy with an opportunity to make a significant first step in addressing the constitutional requirements of the Supreme Court.

The Union of Ontario Indians recommends that the committee on social policy and the Minister of Health and Long-Term Care adopt the amendments and proposed language set out in our written submission as a means to address First Nation concerns, protect First Nation programs and services and First Nation governments' right to constitutionally protected duty and process. This includes a new definition for First Nation programs and services and a substantive provision that these First Nation programs and services shall not be transferred to LHINs.

The health services integration act and other unilaterally developed legislation do little to respect First Nations' constitutionally protected aboriginal and treaty rights and the inherent right to self-government. A process needs to be developed in Ontario that respects First Nations' rights and puts control of First Nations' health interests in the hands of First Nations people.

The Union of Ontario Indians is advocating for the establishment of an Ontario First Nations health accord. This will offer the Ministry of Health and Long-Term Care a single-window approach to dealing with First Nation governments in the area of health, and is consistent with the government's policy of a new approach to aboriginal affairs in Ontario.

0930

It is our submission that these amendments, coupled with the establishment of a First Nations-Ontario health accord, would provide for the orderly harmonization of First Nations, provincial and federal laws and policies, programs and services in the short- and long-term future.

We recommend that the Minister of Health and Long-Term Care, on behalf of the government of Ontario; the grand council chief, on behalf of the Anishinabek Nation; and the Ontario regional chief, on behalf of the Chiefs of Ontario, explore the development of a First Nations-Ontario health accord that will govern First Nations and province of Ontario relationships regarding health in Ontario.

The First Nations-Ontario health accord would establish a foundation of mutual respect and understanding to foster and facilitate a continued evolution of the naturally

evolving collaboration of First Nations and mainstream health systems. In this way, the individual LHINs would come to know some of the unique health needs and aspirations of First Nations members residing on and away from their reserves in a comprehensive and orderly manner with the assistance of, and in conjunction with, First Nations governments and health technicians.

With regard to a First Nations-Ontario health accord, our objectives include but are not limited to the following: to safeguard our aboriginal and treaty rights and the government's fiduciary obligations to provide health services to First Nations; to enhance the health status of our First Nations citizens residing on First Nations lands or away from First Nations lands; to implement the Kelowna accord and the aboriginal health blueprint in a mutually agreeable way that respects First Nation rights; to govern First Nations and province of Ontario relationships regarding health in Ontario, including health integration initiatives and the aboriginal healing and wellness strategy; and to develop mutually acceptable health integration models between provincial health providers, Health Canada initiatives and First Nations health providers.

I will forgo any questions until the conclusion of the Anishinabek Health Commission's oral presentation to this committee.

The Chair: Please go ahead. We still have 13 minutes.

Ms. Deb Pegahmagabow: Greetings and warmest hellos to our grand chief, to the chairperson and members of the standing committee on social policy, and to our elders and others present. I would like, as well, to acknowledge and thank the Mississaugas of New Credit. This is their historical land base on which we conduct business today. I say meegwetch.

My name is Deborah Pegahmagabow. My spirit name is Enaatigohkwe, which is Maple Tree Woman. As it was explained to me, I am someone who brings new ideas or reformats old ideas into newer ways of thinking. I think my role as a band member of the Wasauksing First Nation and currently the health director for the Union of Ontario Indians health program allows me a bit of latitude in sort of taking those ideas and reshaping and helping our communities to reformat health and integration in terms of how they see it.

I come today, as have our Grand Chief John Beaucage and our Elder Merle Assance-Beedie, to bring forth issues on behalf of the Anishinabek Health Commission, the technical and political steering committee of the Union of Ontario Indians, who on a very regular basis advise me and the political department of the Union of Ontario Indians on options that can be taken in the overall strategic direction of attainment of *mno-maadzowin*, the good way of life, for the collective interests of our 43 First Nations in our territory.

You may ask yourself, how does the Union of Ontario Indians and the Anishinabek Health Commission accomplish this task? To be honest, it is not easy. As noted by our grand council chief and our elder, we have 43 First

Nations that stretch from Thunder Bay in the northwest to the Ottawa Valley in the east and across to Sarnia in the southwest. It is accomplished through the Anishinabek Health Commission, a body that meets on a regular basis to foster capacity building at the First Nation level, advocate on behalf of the Anishinabek Nation on health issues, facilitate co-operative planning and establish an effective and open communication process, all of which are dependent upon the Union of Ontario Indians health secretariat to organize and facilitate in addition to providing transfer payment processing of financial allocations to both the seven area health boards and the 43 First Nations' programming dollars via memorandums of agreement. The tasks are varied and concerns are raised on the application of another bureaucracy to oversee and attempt to enhance *mno-maadzowin* in a process where we were definitely not an active partner.

Both political and technical representatives through a network of seven area health boards meet to provide an effective process for the overall vision of *mno-maadzowin* for our people and our territory. A strategic planning process took place last fall that brought both the Union of Ontario Indians board of directors and the Anishinabek Health Commission together for the first time since the forming of the commission. Presentations by health staff on external and internal challenges to both organizations were discussed, and elaborations made on current activities of all the files were made available both verbally and in written format.

One of the files identified in December 2004 as needing attention by way of coupling both political and technical lobbying was local health integration networks. Preliminary issues brought to the attention to our leadership since December 2004 were the sweeping community consultations that did not offer a forum for First Nations to be consulted with, an item brought directly to the two system leads on the LHINs at one of the larger consultation forums in Toronto, where a short overview of the implications for such movement would result in many voiced concerns on the lack of consultation and follow-up on commitments made to renew and strengthen relations between all levels of government, inclusive of our First Nations government.

I have with me a listing of all our First Nations and where they may fall within the LHIN structure. It is unclear to me just how many LHINs our political office and the health program may have to intervene with on behalf of First Nations. We are looking at First Nations in LHINs 1, 2, 8, 9, 11, 12, 13 and 14; 12 and 8 are questionable. This a major concern. We have the political leadership; we have established programs and services within our territory. The Union of Ontario Indians health program serves as the secretariat to our 43 First Nations. The question still remains: Why wasn't our leadership engaged in government-to-government planning on legislation that is going to have major impacts on our people's current and future programs and services?

I meet with you today as the technical representative for all of our 43 First Nations. They are concerned and they are worried. As indicated by the Anishinabek Health

Commission, the commission supports the recommendations provided within the final report of the First Nations task force on LHINs and further provides support to the Anishinabek leadership in the establishment of a federal-provincial-First Nations health accord.

Meegwetich. Thank you for this opportunity to speak.

The Chair: We have a couple of minutes each. I'll start with Ms. Wynne.

Ms. Wynne: Thank you for being here. We have heard a number of times the concerns about previous consultation, but there has been an ongoing conversation with the minister. I don't know what amendments have been brought forward—we haven't seen all the amendments yet—but I'm encouraged that you were able to meet with the minister yesterday, Mr. Beaucage.

You asked about whether the amendments that have been brought forward will meet the needs of the First Nations. I guess I would put the question back to you: Without going into the details, are you optimistic that the recommendations that have come out of the consultations between you and the minister are going to go some way to address your concerns?

Grand Council Chief Beaucage: We haven't seen the amendments as well. There was a promise by the minister that they would go a long way to accommodating our concerns, but until we see them, we really don't know. I guess one of the big things is that we are concerned that we are going to be lost within the LHINs. There are special concerns that we have with regard to our health issues out there, and we have been asked if we can take a spot on the LHIN board, but then we have one person versus maybe 12 or 13 others. In the long and the short of it, we could be lost unless we have special performance indicators within the LHINs.

Ms. Wynne: Okay. One of my concerns is that up until now things haven't gone so well, from your telling of it, and my hope would be that as we try to push the organization and the planning for health care into more local areas, there would be more chance that the voices that need to be heard would be heard. I understand the government-to-government dialogue; I have heard that a number of times, and I understand that. If I thought that things had gone really well up until now, I might be more worried. But because they haven't—you haven't been satisfied that your needs have been met—my hope is that, moving forward, things will be better. So we'll wait and see the amendments. I appreciate your taking part and coming to talk to us today.

Grand Council Chief Beaucage: Thank you very much. I guess it's one of these things that can't get any worse. I'm hoping that it's not like that.

Ms. Wynne: It's going to get better.

Grand Council Chief Beaucage: I'm hoping it is going to get better, yes, and I'm hoping that the amendments will be more positive. As soon as we see them, we will be commenting directly to the minister about that.

0940

The Chair: Mr. Miller.

Mr. Norm Miller (Parry Sound-Muskoka): Thank you, and welcome to Queen's Park, Grand Chief, and

Stephanie and Merle. Thank you for educating us about Mno-maadzowin, the good way of life. I did want to get on the record that you had requested a meeting; I think it was at Garden River First Nation. I did write to the Chair requesting that.

Grand Council Chief Beaucage: Thank you very much.

Mr. Miller: Obviously, the wish was not granted.

Grand Council Chief Beaucage: Correct.

Mr. Miller: You note in your presentation that the spirit of the new approach to aboriginal affairs has not been met and that the consultation has not been the sort of consultation that you would like to see in terms of government-to-government consultation. In a perfect world, what sort of process would you like to see in terms of consultation between First Nations and the government when the government is implementing a bill like Bill 36?

Grand Council Chief Beaucage: I guess, in a perfect world, there would be recognition that we have governments as well and, when there are new legislative initiatives being proposed, that there be a process to engage us, not as non-governmental organizations or interest groups but, because these affect our communities and our governments, that we get together on how the consultation will proceed and will ensure that that particular legislation, which affects us very strongly, is worked to make sure that our concerns are looked after in a good way; that it's not a top-down approach but it's a collaborative approach to make sure that the concerns are looked after. We've made the recommendation to a number of ministers that we would be prepared to be involved in it.

Mr. Miller: So more involved from the beginning, basically—

Grand Council Chief Beaucage: Yes.

Mr. Miller: —in setting out how the consultation—because from the government's perspective, this is consultation, basically; so planning the consultation as well.

Just one other quick question, because I probably don't have much time: What sort of representation would you like to see on the various LHIN boards from First Nations?

Grand Council Chief Beaucage: Well, our proposal of a First Nations health accord actually is keeping within the LHINs but separating our health issues just to one side of it. It's like a parallel approach. There would be indicators, performance standards, accountability measures and so on that would be parallel but somewhat separate, so that the dollars that flow specifically to aboriginal health are kept within the First Nations health accord and the parallel approach is kept all the way along. It's not separate from LHINs but it's adding to the LHINs.

The Chair: Thank you. Mr. Prue, please.

Mr. Michael Prue (Beaches-East York): Thank you very much. Let me preface my question with an apology: I'm a late substitution. I got called: "You'd better get down here fast." I understand my colleague Ms. Martel is

not well today. I missed some of your deputation and for that I apologize.

I just want to get back to the government-to-government. This is something I hold very dear, and I think that for too many centuries politicians and general society have not dealt with the aboriginal peoples as a government. What can we do to strengthen that around the LHINs and everything else? What can we do to strengthen that so that politicians always know that they're dealing with another level of government? We know that with the mayors, we know that with the municipalities, we know that with the federal government, and I don't understand why we don't know that when it comes to aboriginal communities.

Grand Council Chief Beaucage: I think a great deal of it has to do with attitude on the part of all governments, federal and provincial.

I was at an official opening about a year ago where a very prominent member of the provincial government talked about the three levels of government in Ontario, and they were federal, provincial and municipal. If you went back to some of the high school courses, you'd know that municipal is not a level of government; it comes under the provincial government under a ministry. That third level of government is the First Nations. I think attitude and education would go a long way to making sure that that is there. I think that when the Constitution is reopened at some time in the future there will be a constitutional amendment that will make sure First Nation governments are the third level of government. It was proposed at Meech Lake, which didn't go, as we all know.

So I think it's attitude first and foremost, that we have to be involved early on in any process.

Mr. Prue: This year is also the 100th anniversary, I believe, of Treaty 9.

Grand Council Chief Beaucage: Yes.

Mr. Prue: That was a signature between the federal government, the provincial government and all of those people in northern Ontario. I don't believe that that treaty has ever really been enacted or upheld, in much the same way. It seems to have been ignored. Now I'm seeing the LHINs, and I'm seeing the same thing. Is that a pretty good parallel, or am I mistaken?

Grand Council Chief Beaucage: I think that's a fairly good parallel and, just to emphasize that point, our treaty Robinson-Huron/Robinson-Superior is 156 years old. Many of the provisions under that treaty, including resource-sharing, have yet to be met.

The Chair: I want to not only thank you for the presentation but to make sure that you appreciate that your request to Mr. Miller was evaluated, and a number of others, because Mr. Miller did send me the request.

Unfortunately, there were a number of requests and there was a perception within the subcommittee that we could address, as much as possible, issues through the process we went through. I'm happy to see you here today and to hear you in person. We also today and yesterday have been hearing people through teleconfer-

encing, which is quite convenient. We can see each other. They can see us there and we can see them here, but the message is clear. That's why, unfortunately, we did not visit your location. But we thank you for coming today.

Grand Council Chief Beaucage: Thank you very much to everybody.

OLDER PERSONS' MENTAL HEALTH AND ADDICTIONS NETWORK OF ONTARIO

The Chair: The next presentation is from the Older Persons' Mental Health and Addictions Network of Ontario; Randi Fine, executive director. Good morning, Madam Fine. You can start any time you're ready, please.

Ms. Randi Fine: Thank you very much for allowing us to present. I'm really delighted to be here. Our presentation and our requests, in fact, are fairly simple, although the issues that we're concerned about are actually very complex. I'm going to try to talk fast and get a lot of information in fairly quickly. My passion often runs over. I represent the network, not only as the executive director but as a family member of someone who lived with bipolar disorder and manic depression for many years. So these are issues close to my heart and to those of many of the people of Ontario.

What you have been given is a detailed background package. I don't expect you to read the whole thing this minute, although I hope you will at some time take the time to do that. I won't read the whole thing to you either.

You also have a brochure in front of you. That's part of our depression and aging campaign. Just so you know, a display unit like this with those pamphlets in French and/or English is going to be distributed through every family doctor's office across Ontario, because we are very concerned about depression and aging, as we are about the other issues in mental health and addictions and aging. So that's part of our campaign.

First of all, what is the Older Persons' Mental Health and Addictions Network? We do call it by an acronym, which is almost as difficult: OPMHAN. OPMHAN was founded in 2000 provincially across the sectors of aging, mental health and addictions, bringing people together who work in the field, who live with the conditions, who are concerned about the growing numbers and the growing concerns of people living with those kinds of concerns.

We define "older" not by age but by the way people live their lives. As some of you may be aware, when you deal with chronic illness of any kind, certainly mental illness and with addiction issues, you may age as if you are chronologically older than you typically are. Someone who has dealt with any kind of life stress may have issues at an earlier age. We avoid the number, but we are talking about people growing older. We are talking about aging.

0950

In terms of mental health, to clarify, we're talking across the very broadest spectrum of mental health. We're talking about those people who are growing older with conditions like schizophrenia, manic-depressive disorder, bipolar disorder, but also those people who have conditions that are related to aging. Of course in mental health we also include the dementias, but frankly, because there has been a fair amount of attention given to dementia, we are focusing more on conditions like depression. You may be interested to know that depression—and we have very poor relevant Canadian statistics—affects at least 20% of older adults, and probably, unfortunately, much closer to 40%. We also know that much of that is preventable.

In terms of addictions, we are talking about substance use and substance misuse, drugs that are by prescription, alternatives, all of those kinds of things; also alcohol, smoking and problem gambling. We're very broad-ranging.

We are concerned about issues from the one end of prevention and health promotion right through to end-of-life issues. We're really kind of all-in-one.

We have been addressing huge unmet needs. Just trying to figure out what those needs are for the last five or six years has kept us extremely busy. Our membership now, which is free, open to all committed individuals—so people have to sign off—includes 60 provincial organizations, 300 individuals who have themselves experienced the mental health or addiction system and, through e-mail and quarterly meetings and a provincial conference etc., we reach 4,000 individuals on a regular basis.

Our funding, at this point, is project-based; we don't neatly fit any silos—I'm sure you've heard that word before. We are really crosscutting. We don't have any funding from the provincial government, and we don't have any funding from the federal government either. What we do have, which I really do want to acknowledge, is support from the Ontario Seniors' Secretariat, which in fact is housing our office and providing clerical support and teleconferencing and frankly allowing us to survive. We recently received a major grant from the Ontario Trillium Foundation, which is funding us for three years and providing core support until we can find a way to sustain ourselves further.

What we do: We focus on raising awareness about older adults' mental health and addictions. We look at supports for family members and older adults themselves in terms of groups, counselling, physical activities, all of those issues. The only direct service, if you like, that we provide is training and education. We provide training across the province and have done numerous presentations. We do direct training for front-line staff, personal support workers, people in contact with older adults and public education almost where anybody will listen to us.

We have been involved, and I think this is really pertinent, in the development of regional affiliates. Because we are fairly new, because we came about at the time that

the LHINs legislation was being discussed, we have been developing our regional affiliates in line with the 14 LHIN regions. We have six already developed, and hopefully we'll have all 14 in place within the next six months.

Part of our focus, of course, is giving voice to key messages. That's what we're here to do today.

Why are we here? Why do we care? Why do we hope that you care? Pretty simply, we know that people are living longer, that more older people in the community means that there will be more people at risk of and coping with mental illness and addictions, and more families in communities affected. I won't ask for a show of hands, but if I did, it's likely that most people in this room would know someone who has been affected by a mental illness or addiction. That means that most of us have been affected as well. Mental illness and addictions are devastating life conditions. People growing older with mental illness and addictions have all the problems that people do growing older anyway, as well as the additional issues. And so they face the stigma of the disease as well as ageism and the complexities of aging.

There is little relevant Canadian or provincial data available. In part because of the stigma, very little research has been done. For example, research on anti-depressants has almost never been done using older people as the original research subjects. But we know that, for planning purposes, in Ontario we have very little data beyond the long-term-care sector, and that's a concern for us.

The good news is that prevention and early intervention can make a huge difference. Medical treatment, in combination with strong community and social supports, works. We know that we are at a crossroads here. There are more older people. There is more mental illness and addiction. Some of that could be prevented; much of it could be made easier to cope with. But we need to focus on these issues in a way that our network—and, to date, only our network—has really brought people across the sectors together to do. So we know there's a huge need to raise awareness and educate older adults, family members, service providers and the public, and that's our role.

If we can add to the LHINs discussion, we ask you to recognize that older adults' mental health and addictions are a prime example of the complex interactions between factors that contribute to health and impact on the broader community. We want to ensure that our unique population is represented, as everybody does. We want to point out that mental health and addictions themselves, as well as seniors' issues, as you probably are all aware, were listed among the top priority issues at the consultations for every LHIN across the province. We know that these need some attention.

We want to recognize the recommendations of the Elder Health Elder Care Coalition. Some of you heard their presentation, I believe, on Monday. OPMHAN is a steering committee member of that organization and was a signatory to those recommendations. But we want to

take them a little further. Out of concern that Bill 36 does not include clear provisions for community input—and I know we're not the only ones who have mentioned this—we want to recommend that a seniors' advisory committee be struck for each LHIN and for the ministry, but also that these committees include representation from those concerned about older adults' mental health and addictions. It's really important that within those committees, which we really hope will come about, there be special representation around these issues which affect so many older adults.

We want to make sure that Bill 36 is amended to include explicit parameters for public engagement in the development of the ministry's strategic plan. I heard my colleagues in previous presentations talking about a role for provincial organizations. Certainly, we're not the only ones concerned about this. We, as you've heard, are very concerned about making sure that there is regional representation, but we also know that there are cross-cutting issues across the province. We'd like to see a role for provincial organizations in these discussions, and that, as we say, our regional partners be included at the LHIN level.

I'm going to leave it there, asking you to remember that we are the only inclusive, cross-sectoral provincial network devoted uniquely to improving the system of care for older adults struggling with mental health and addiction issues, and to offer OPMHAN's assistance as the LHINs move forward to include this important population.

The Chair: Thank you. Less than 30 seconds each. Mr. Miller.

Mr. Miller: So your primary concern is that there aren't clear provisions for community input, and your main recommendation is that a seniors' advisory committee be struck?

Ms. Fine: Including some representation around older adults' mental health and addictions.

The Chair: Thank you. Mr. Prue.

Ms. Fine: Was that the question?

The Chair: It was 30 seconds.

Mr. Prue: Your organization is a fairly new one, and you said you have been able to develop it along the lines of what you anticipate the LHINs are going to be. I'm just worried that if you go too far and the LHINs are changed—because that's what I've been reading in the newspaper, anyway—how difficult will it be for you to change that at this time?

Ms. Fine: The truth is, we have representation and interest really throughout the province. To be politically astute, we have attempted to set up the regions within these 14 boundaries, but they are really local to their own communities and integral to those communities.

The Chair: Thank you. Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Thank you, Randi. It's nice to see you again. It's great that you are already developing a model that mimics the LHINs. What you've done bringing so many organizations

together is exactly what the LHINs want to do, to create that integration.

At many of our consultations where we've had—well, the numbers differ—between 4,000 and 6,000 people who have made presentations, many of them have been seniors groups around community support services, home care, and really bringing forward all the barriers and the lack of integration. Do you feel that the LHINs will be able to make patient care a lot easier for the patients so that they don't jump through hoops, especially seniors who find it difficult, at times, to navigate the system?

1000

Ms. Fine: We hope so. I have to say that I've been around since the days of one-stop shopping, which was a long time ago. So, yes, we hope so. I think there is a possibility that that can happen. I think it's going to be very important to make sure that the voices of people are heard, that seniors' voices themselves are heard, that the issues are crosscutting: recognition that seniors don't live in a box, that they live across all the boxes. So integration and collaboration can work, and we're hopeful.

The Chair: Mr. Miller, do you still have a question, a quick one?

Mr. Miller: Certainly, just in terms of the size of the LHINs. They're called local health integration networks, but the concern is that they're less local than what we currently have, especially if you get into the northeast and the northwest, where they're immense geographic areas. My own riding, Parry Sound, and James Bay are in the same LHIN, to give some idea of the size. How do you address that to make sure it is local?

Ms. Fine: It's as difficult for us as it is for—"us" I have to explain to you. We have a staff of one; you're looking at it. It's difficult for anybody to be anywhere. We use communication tools much as everybody else does. We use e-mail; we use telecommunication. We attempt to meet the needs and to find out what the needs are, recognizing that within one LHIN area or within one province or within one region there are going to be many, many differences and that each LHIN is going to have to address all kinds of differences, including those of geographic disparity.

Mr. Miller: So your advice is a committee for each LHIN—a seniors' advisory committee?

Ms. Fine: With the understanding of that particular LHIN's issues.

The Chair: Thank you very much for your presentation.

ONTARIO FEDERATION OF INDIAN FRIENDSHIP CENTRES

The Chair: The next presentation is from the Ontario Federation of Indian Friendship Centres; Sylvia Maracle, executive director, and a friend. Good morning.

Ms. Sylvia Maracle: Good morning.

The Chair: You can start any time you're ready, please.

Ms. Maracle: We did deliver a written submission to your clerk a day or so ago. I'm hoping they're going out.

Let me begin first with greetings. I'll be very interested in how you translate this in the minutes.

Remarks in Mohawk.

It means, "Greetings, and I hope great peace is with you."

The Chair: Thank you.

Ms. Maracle: I am Sylvia Maracle. I'm the executive director of the Ontario Federation of Indian Friendship Centres. On behalf of the federation, I'd like to thank the committee for the opportunity to make this submission today. I'd also like to thank the Mississaugas of New Credit, who are allies and who are our gracious hosts, in both the collective sense of the federation and this committee, and of course this building.

The Ontario Federation of Indian Friendship Centres is a provincial organization and umbrella group of 27 friendship centres, whose job it is to provide culturally relevant services in the areas of health, justice, employment, children's programming and youth, and we do that in what we refer to euphemistically as a status-blind process. It doesn't matter to us if you're a First Nations member, Metis, non-status or if you are indigenous from somewhere else. We've been doing that for 37 years in Ontario.

In our proposal, we detailed a number of health conditions. I think it's sufficient to say that the aboriginal community, irrespective of their residency in Ontario, suffers poor health, and all of the strategic approaches that are supposed to be tied up in Bill 36 have not resulted in improving those health situations. So I'm here today to voice a number of concerns on behalf of the federation.

You've already heard that there is rarely unanimity in the aboriginal community. It's very rare that First Nations, Metis women and men, on-territory and urban, agree. Oddly enough, Bill 36 has given us the opportunity to agree. We can rally around the notion that we have not been consulted, that we have not been recognized in terms of a rights-based agenda, that there are somehow amendments that are going to appease us that have never been shown to us; they're just promises. In fact, that's no different from the behaviour that has arrived with the tabling of this legislation that the committee is considering. We're going to be asked to be happy with an 11th-hour decision that someone has made in our best interests without talking to us, once again.

I brought for the committee—and we were perhaps bold, but we actually sent this to your committee clerk. This is the aboriginal health policy in Ontario. It was created in 1994. Perhaps you didn't personally sit in the Legislature, but all of the governments represented on this committee have had an opportunity to either concur, to amend or to get rid of it, and none of you have. So it existed and it exists today. The issues around representation, around engagement, around community involvement, around ownership, around the kind of health processes that have to be amended have been spelled out

consistently since then. As far as I know, none of the organizations or governments who were involved in creating it have said, "We're withdrawing our support." It's still on the table.

We will also argue that the proposed bill that looks at integrating and improving health coordination issues will, in the end, create exactly the kind of competition that we've experienced so far: a competition over resources, in the broadest sense of money or human resources, and unfortunately around power and control: Who has the right to make what decision? Those competitions have failed us in every instance, not only in this province but across the country. But we're talking about this province.

We've also recognized that, over time, our experience has been that certain groups of health care professionals, social planning people and others will use aboriginal issues as a way to get resources: "Oh, we've got this many aboriginal people in our area; this many aboriginal people live in this city. They experience poor health, and we really need something." The fact of the matter is, the numbers play the game, but they don't result in services and programs for our communities. The very few that we've been able to develop over the last number of years are now subject to being sliced so small in this bill that it's potentially a further step by Ontario as a collective to—not only does it not acknowledge our rights, but it doesn't acknowledge and give credence to the organizations and the infrastructures that we've created to provide services; in this instance, health services.

We tried as a federation to participate in the consultations, as did other urban aboriginal people, and we found that we were relegated to diversity groups. It doesn't feel very good in the diversity area. Immigrants and refugees, visible minorities, the gay/lesbian/bisexual/transgendered community, sometimes francophones, sometimes women and certainly the disabled all get lumped into the diversity group, and somehow we're expected to rise to the top, when in fact we probably are representative of all of that. So we tried in consultations—and there were flip charts going around the room in Toronto, London, Ottawa and other places, and all of a sudden "aboriginal" would appear. Then the facilitator would go through the process of discussing LHINs, and eventually they needed to prioritize, to take all these down. They got boiled down and boiled down until we didn't get on a sheet.

We wrote to the minister on a number of occasions. He has not met with us; he hasn't even answered our letters. So when you talk about feeling that maybe there's some light at the end of the tunnel in terms of amendments, we don't know that to be true.

You have to understand that aboriginal health care needs are much more acute than the general public's, that there are all kinds of barriers. Sometimes, we don't like to talk about those barriers. We go through trends where we say the word "racist" and where we don't; we try to get along. The fact of the matter is, in urban areas, people do not feel compelled to go to mainstream services. They would rather just get sicker and let health situations that could be addressed become more chronic, because

they're not prepared. They're not prepared with what they see, what they feel, what they face when they arrive, so they avoid them.

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We have evolved over a period of time some community engagement, some community approaches. We're having conversations with the political leadership to try to create a better process. LHINs undermine that whole discussion, and they undermine it in a number of ways. We were party to a conference recently about the creation of aboriginal health care professionals and how we need doctors, physiotherapists, speech therapists, audiologists and all kinds of things. We participated in a conference with First Nations and our other colleagues called Vision 2020. We're talking about being able to start addressing that curve by 2020. LHINs will very much be driven by professionals who are recognized today, not in a future sense. They're not going to wait for us to catch up. The competition is going to continue, and the issues that were raised and the health policy around the lack of sensitivity of this other layer of bureaucracy now are simply going to be reinforced.

We've written and we've written and we've written. None of them has been answered. We haven't had a meeting. We haven't even been invited to a meeting with the minister. So certainly, as the Ontario Federation of Indian Friendship Centres, we don't feel consulted, and we are not sure there's a light at the end of the tunnel.

The new approach that the Ontario government created with respect to aboriginal affairs recognized the importance of programs delivered by aboriginal service providers in Ontario. That approach also recognized a greater involvement of aboriginal people in matters that directly affected their communities. The new approach said it was going to foster genuine understanding between the province and aboriginal people to help clarify shared priorities. It's very difficult for us to believe, in terms of this legislative development and the relationship of LHINs that will evolve, that any of that is going to be true, that any of it can be realized.

In our document, we made two specific recommendations. This government has the capacity to exempt aboriginal people. You've already done it in the Tobacco Control Act, in the midwifery legislation and in the regulated health professions. So you already have a precedent. It can be done. There has been a will in previous governments to do so.

Our primary approach would be exemption, that aboriginal people, our services, our programs and health issues would be exempted. Whether that exemption follows the notion of a formal health accord, as the grand chief who spoke just before me has suggested, or whether it's a secretariat that's created to address health, as the Chiefs of Ontario talked about, I think it's possible to be creative about how it can be addressed.

I think if you cannot and will not look at an exemption that allows us to preserve our culturally appropriate services and programs, that looks at not micromanagement but macro issues and real planning with respect to aboriginal health, then you might look at the creation of a

15th LHIN, an aboriginal-specific LHIN. Again, it could be a secretariat, it could be managed by an accord, it could be struck however. But for us, in terms of what we've experienced, the bill that you're proposing, that you're considering, is not going to meet our needs.

Bill 36 needs to be changed. It needs either an exemption or a different way to engage us.

The Chair: Thank you. There is 30 seconds each. Mr. Prue, you are first, please.

Mr. Prue: I don't think any member—I know that not one single member was here in 1994 who is around the table today. I was just having a read of this. I think number 11 says it all. Number 11 says, "First Nation/aboriginal communities' control of health needs assessment, planning, design, development and delivery of community-based health programs and services is essential to improving aboriginal health. Aboriginal people will define and negotiate the level of their participation in the governance of health programs and services available to and accessed by their communities."

That's really what you're asking for today: something that was set out in a paper in 1994 and that you have not seen, but if you did see, would resolve the difficulties you have.

Ms. Maracle: Absolutely. The document lives and it survived. As I said, all of your parties were involved in forming government at one point. I don't understand why something that has already been supported, that an all-party committee can support, you can't.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. I wanted to ask you about the contact with the minister. If you could get us the details of the letters, I'd like to track down where those are and get you a response.

Ms. Maracle: I'd be happy to do that.

Ms. Wynne: Our understanding is that the minister has attempted to meet with the First Nations groups and have this discussion leading to the amendments, albeit they are not here on the table for any of us to see yet. If we could track down those letters, that would be great. If you could let me know—

Ms. Maracle: Sure.

The Chair: Mr. Miller.

Mr. Miller: I was going to bring up the point that Ms. Wynne just did, that the minister has not responded to your letters. I'm surprised that he hasn't either met with you or responded to your letters.

In terms of representation, one possible ideal solution is the creation of a 15th LHIN specifically for First Nation concerns.

Ms. Maracle: As a second option. Our first option would be the acknowledgement that aboriginal health issues fall outside of the LHINs discussion and we would have a full exemption. We have demonstrated three other pieces of legislation where that has occurred already. If there has to be an engagement in this process, then it really needs to be aboriginally distinct.

The Chair: Thank you very much for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1999

The Chair: The next presentation is from the Canadian Union of Public Employees, Local 1999; Joanne Wilson and Lorrie Boake. Ladies, you can have a seat, please. Whenever you're ready, you can start your presentation.

Ms. Joanne Wilson: I'm Joanne Wilson. I'm president of CUPE Local 1999, Lakeridge Health hospital. I'll give you a little history. We are a five-site merged hospital: Uxbridge, Port Perry, Bowmanville, Oshawa and Whitby. That happened in 1998. Since then—and this was done through the restructuring committee—the Uxbridge site has been sheared off and realigned with the Markham-Stouffville site. So now I am president of one local, with a subsector in Uxbridge. I represent approximately 1,350 health care workers ranging from nursing staff to clerical staff to service staff within Lakeridge Health and Uxbridge.

Thank you for allowing us to come today and present. I'd like to thank CUPE for helping with research on this as well. We're here today about the centralization, consolidation and privatization that is proposed in Bill 36. Once again, the Ontario government wants to transform health care and certain social services, this time by creating local health integration networks. Fourteen LHINs have been established in the past year to plan, integrate and fund hospitals, nursing homes, homes for the aged, home care, addiction, child treatment, community support and mental health services. Ambulances and public services have been excluded initially, along with privatized labs and clinics. The government has allowed doctors to escape the LHINs. If passed, Bill 36 will give governments and the LHINs new and troubling powers to restructure public health care and social services.

I must make an admission here: I forgot to introduce Lorrie Boake. She's a vice-president of our local. I'm a little nervous, as people have probably seen already.

The Chair: You don't have to be; all friendly faces here.

Ms. Wilson: Okay, I'll continue on. I'm not going to read this document verbatim. There are certain issues in this document that Lorrie and myself are going to address that we feel very strongly about. One of them is centralization.

The LHINs are local in name only. We're LHIN 9. Our geographic area goes from Toronto up to Haliburton, Algonquin Park, Campbellford hospital—all those huge areas. If we look at the definition of "local" in the dictionary, that's not what LHINs are; they're not a local service at all. Our concern is that, with this huge geographic area, how will our local community have any say in the services that are provided within our community?

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I'll go into this. The LHINs are local in name only. The bill will grant little real power to local communities and providers to make decisions. Rather, it transfers

control over local community-based providers to the ministry, the cabinet and to their agents, thereby centralizing, rather than localizing, control over health care in Ontario. The bill grants unprecedented authority to the Minister of Health and the cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

The government describes the legislation as a made-in-Ontario solution that would give power to the local level. It distinguishes this reform from regionalization in other provinces, as LHINs will not directly deliver service. In fact, the government reform takes the worst aspects of health care regionalization in other provinces and combines them with the worst aspects of health care restructuring in England. It would create a new layer of bureaucracy that would be unaccountable to local communities, reduce provincial government accountability for the largest part of its budget and create a purchaser-provider split that will undermine health care and social services.

What follows is an outline of these problems. The LHIN covers vast and very diverse areas. The LHIN boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local; they are not based on communities and they do not represent community interests. As a result, they lack political coherence.

The definition of "local," like I said earlier, is "of or relating to a small city or town or district rather than a large area. Not broad or general. Not widespread." Our LHIN, LHIN 9, is the size of a small country, going from Toronto to the border of Algonquin Park. How can this be defined as local? It will be very difficult for people living in a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

The autonomy of the LHINs from the government is very modest. With this bill, cabinet may create, amalgamate or dissolve a LHIN. A LHIN is defined as an agent of the crown and acts on behalf of the government. LHINs are governed by a board of directors appointed by cabinet and paid at the level determined by cabinet. The government determines who will be the chair and vice-chair of those boards. Each member continues on the board at the pleasure of the cabinet and may be removed at any time.

I have a huge concern about this. Where is our community's voice in who sits on our LHIN board for our local? This is our local community health care network. Where do we have a say in who is picked for these boards? These directors should be elected to these positions by the communities, not appointed by government. That's one of my huge concerns, because then there's no accountability to those who elect you. As you know, as representatives in Parliament, you're accountable to your constituents. How are these boards accountable to the community? That is a huge concern with me.

The LHIN boards will be responsible to the provincial government rather than local communities. This is in contrast with a long history of health care and social service organizations in Ontario which, as a rule, are not appointed by the provincial government. For example, hospital boards are not appointed by the provincial government. They have doggedly pointed out the need for better care in the communities, with significant success. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were revised and the hospitals were allowed to continue to provide decent, if still underfunded, care.

This happened in my own community. Port Perry was one of our small, rural sites in this huge hospital setting. Port Perry was going to lose its maternity services in that hospital, and it was the community that got together, along with the doctors, and said, "This community needs those services." If not, they would have to drive to Oshawa to be provided with those services, because they've already lost those at our Bowmanville site, as well as at our Whitby site. The problem with this is that in the winter you're going through an area that, if it was like the other day with the snow, you might not get through to deliver your baby.

Again, in Ajax just a few weeks ago, there was a protest by 1,200 citizens about the closure of their pediatric and mother-baby care area, and that process has stopped there as well. These are community hospitals. They are based in the community, with the needs of the community in mind. When we do these huge local areas, that is lost.

Another point in the LHINs legislation with the LHIN boards being set up is that they are going to take all the flak for any decisions that are made, but in reality the decisions are being made by the Minister of Health and cabinet, because the LHIN board is totally accountable to the minister and to cabinet. They have to sign accountability agreements with them, as well as accountability agreements with the hospitals. But where is the accountability agreement with the communities? Where is the accountability back to the communities? That's my concern. It's flowing from the government down to the community, and any accountability should always go to the community first. That's where I see a lack in this bill. There should be accountability agreements signed with the community and not with the government.

Right now, we see hospitals having to sign accountability agreements with the government, and there are gag orders put on the hospitals for any of their funding changes. I sit on a fiscal advisory committee of our hospital, and we have been told what the budget cuts are. But we were also told at those meetings that we couldn't tell the public about any of those cuts because the hospital was under a gag order, and if they told the public about these cuts they were afraid they were going to lose the funding they might achieve from the government. This is wrong.

The public has a right to know what cuts are going to be introduced and what services are going to be affected in our hospitals. Making accountability agreements with the minister and cabinet, and then the hospitals having accountability agreements with the LHINs, is not the process that should be happening. The accountability should be to me as a taxpayer and to the public and the people who are in that LHIN. So the reverse needs to happen there. The gag orders that hospitals are being put under about their budgets need to stop. I as a citizen need to know what services may be taken out of my community and passed on to another hospital.

I'll give you an example. They talk about hip surgeries, knee surgeries and eye surgeries all having to be centralized and rationalized. Right now, they're performed in our general hospitals, and people have access to those hospitals. Someone in Campbellford only has to drive to Peterborough. If you make the one hospital in the LHIN that might be doing hip surgeries in Scarborough, that's a two-and-a-half-hour drive for that family. So if my mother has to be in that hospital and I live in Campbellford and my father no longer drives, how is he going to get there to see her?

I have experienced this myself. I had a child who, for two years, had to be in Sick Children's for chemo treatment. The impact on a family when that happens is devastating. First of all, the illness is devastating, and the travel is even harder. Now you're proposing this for the whole province? Until you're in the situation, you don't know how hard it is. I only had to travel from Oshawa to Toronto, but I had two small children left at home that I couldn't care for while I was travelling to Toronto.

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Take that and make it two and three hours for families having to travel for health care. What are you doing? This isn't improving our health care. What you're doing is making it harder on families, making it harder for women and families, because they are usually the health care givers for their elderly parents, their sick sisters and brothers and, a lot of times, their sick children.

This is a hardship that no one should have to undergo. What you're proposing with this bill is only going to make it harder for people in Ontario—sorry.

The Chair: That's fine.

Ms. Wilson: It may sound good; it's not.

Not only will families have to try to find the transportation, try to find the means to have people transported to these areas, but there's a cost incurred. The cost of travelling nowadays is not cheap, the cost of parking at any of these institutions is not cheap and the cost of an illness to a family is devastating. Add this on top of everything else, and what you're creating here is hardship for the people of Ontario.

I'm going to let Lorrie talk about the service cuts within the bill and the possible rationalization and privatization for profit of non-clinical services within the hospital.

The Chair: We do have your material, so could you just give a summary?

Ms. Lorrie Boake: Sure. We all know that there have already been cuts to hospitals. One of the biggest impacts has been to the support services cleaning the hospitals. With the cuts that have already occurred in health care funding, cleaning services in hospitals have been cut to a bare minimum. With this decrease in cleaning staff, there is an increased spread of the MROs: VRE, MRSA, ESBL, C. diff. and more.

With the competitive bidding and undercutting that will occur with services being contracted out to the private, for-profit sector, which we've already seen with the CCACs, profit and not infection control will be the driving force. The services will go to different companies, time after time, contract after contract.

We've seen the effects of SARS, and we know there will be great or greater challenges and possible pandemics out there. We should be focusing on preventing the spread of infection and increasing infection controls in the hospitals. Cleaning hospitals and health care institutions is not like cleaning a bank. The cost for trained health care cleaning staff is only a fraction of the cost of providing care to people, of increased lengths of stay and of increased drugs to treat MROs and other infections acquired because of the lack of cleaning.

The government plan is to regionalize hospital support services. With government support, with the HBS coming in, this organization would take approximately 1,000 employees out of hospitals and turn a significant portion of our work over to for-profit corporations. These are our health care dollars going to line the pockets of private companies rather than into health care. Like so much of the restructuring, these moves will have a major negative impact on hospital support workers, and they will not create seamless care for patients. Instead, they're going to create more employers bringing more for-profit corporations into health care.

In our own workplace, each hospital had a warehouse section for their stores department. Because we were merged, they have been eliminated. There is one now. Last year, there was a huge accident in Bowmanville, and the supplies they needed to treat that emergency had to be brought over in taxis. What happens now, when the warehouse is in Toronto? What will we do when we need those supplies in Bowmanville, in Cobourg? How will we get them there? It's not like GM. We can't shut down the line until the supplies get there.

The Chair: Thank you very much for your presentation.

Ms. Wilson: I'm sorry about getting so emotional, but this is something that the government needs to understand will affect people in Ontario hugely, not just the workers in hospitals and the possible job losses, but all of us as consumers of health care in Ontario. We have to look at not what is the cheapest way but at what is the best way to provide health care.

The Chair: Thank you. You certainly have a made very clear point and all of us appreciated your comments since they certainly affect you directly. I think we are here for that. The intention is to hear the arguments and

suggested recommendations. I'm sure not only the opposition but also the government will be looking at changes. Your comments will be appreciated and shared with many other people.

INDEPENDENT FIRST NATIONS

The Chair: We'll move to the next presentation, from the Independent First Nations, Chief Paul Nadjiwan. Good morning, Chief. Please have a seat. Whenever you are ready, start your presentation.

Chief Paul Nadjiwan: I'd like to start off this morning by saying good morning to all the members of the standing committee. I want to thank you for extending an opportunity to the Independent First Nations to do a presentation here with regard to the LHINs and Bill 36.

I have provided some notes which we've left here. Since we drafted those notes, we've probably made a few little changes. I don't often read from a script, but I think, based on the time frame that we have here today, I will probably do that this morning. There aren't too many differences in what I have added to the paper that you have, but I'm sure that will all be recorded and that should work out.

My name is Chief R. Paul Nadjiwan from the Chippewas of Nawash unceded First Nation. I'm here to make a presentation to you today on behalf of 12 independent First Nations, which represent approximately one third of the total native population in Ontario. Geographically, these communities represent all of the social and economic constructs, from the largest First Nation to remote northern, fly-in communities.

The Independent First Nations come here to advocate for the transformation of LHINs as a health service mechanism that must address the health issues and needs of the independent First Nations.

There are a number of federal and provincial health initiatives geared toward First Nations, they've been implemented over the last 20 years. Some of them that have involved First Nation intervention and discussion are the Child and Family Services Act, 1990; the Midwifery Act, 1991; the Regulated Health Professions Act, 1991; the tobacco act of 1994 and the food and drugs act, natural health products regulation, 2004. Those are just some areas of legislation that First Nations have actively participated in and provided some guiding thoughts and values.

I guess the position that we find ourselves in is that when committees such as this choose to dialogue and entertain the suggestions and discussions that First Nations advocate, the purpose is always to improve something that is out there, something that will work better at the end of the trail down at the First Nation level. I would ask you to consider that many of these communities are isolated and the communities themselves don't see the types of integration and involvement and opportunities that you will often see in a large city like Toronto. So one has to really understand the factors that create the

challenges that First Nations face. More often than not, First Nations, because they're in this position, actively engage in a process of deconstruction and decompression. This is accomplished through our First Nation technicians and political representatives. This has become a fact of life in the First Nation community, and the LHIN bill, Bill 36, is a current example of policy that requires changes.

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It is well known that First Nations still face the poorest living conditions and routinely face boil-water advisories on a weekly basis. I see that in my own First Nation constantly. We can't even drink the tap water that we have, and it's treated. It's probably difficult to understand that, but it's something that is very real in many of our communities.

When we review our budgets, we typically find inappropriate and insufficient levels of resource allocation that fall short of fully supporting transportation to medical facilities and access to specialized health professionals.

One of the things that commonly happens to First Nations people is, when they go for a medical examination and it's discovered that they have, perhaps, diabetes or a heart problem or various other kinds of health-related illnesses, the doctors will prescribe name brand prescriptions, but when we get to the pharmacists, they're always replacing these things with generic brand drugs. Some of you may have seen that some of these drugs will always have, in capital letters, the acronym APO or GEN. You will often see that, and this is always in place of the name brand. What we know about name brands is that they do have a 20-year threshold for patent. Tylenol is a typical name brand product that has now been replaced with a generic fill-in, I guess. Some people find that when they ingest some of these generic products, there are side effects that exceed the name brand stuff. That's something that I think the health department ought to consider and look into.

The report itself identifies measurable outcomes that will only be achieved if proper planning, development and implementation of strategies are conducted with First Nations through meaningful participation. The Independent First Nations are genuinely concerned that the present LHIN model demonstrates an inferior process by which First Nations, at the community level, end up receiving a poorly designed delivery of health services. The Independent First Nations see the present LHIN model as ignoring the basic, fundamental delivery of health services at the First Nation level because, at the onset, it undermines the level of responsibility and jurisdiction that First Nations know they are capable of managing.

We know that for any health agenda to work, the Independent First Nations must be full and equal partners. In order for it to be an effective process, First Nations need to be involved, and this would include at the onset of policy development, in program planning, in the review stages and being part of all the demographic

and geographical considerations found in these communities. The challenge for the crown is to ensure that legislative amendments flow with the traditional practices, legal obligations and the inherent and constitutional rights of First Nation citizens.

In order to effectively recognize existing First Nation governments and health administrative structures, Ontario must be true to the words that were written in a letter from Minister Papatello of the Ministry of Community and Social Services to Grand Chief Stan Beardy, the chair of the Ontario Chiefs Committee on Health. She wrote, "Aboriginal health is a priority and the crown is committed to building positive relationships and productive partnerships."

The time has now arrived when the crown must engage in a renewed political agenda to establish bilateral relationships with First Nations citizens that work to achieve a network of health initiatives that serve the needs of First Nations citizens. The engagement of a bilateral process embraces unity at the forefront, whereby the crown and First Nations come to an agreement which recognizes the necessity to implement an operational work plan that facilitates well-defined administrative practices and resource-management contingencies.

Therefore, the bilateral process establishes a communication mechanism that objectively and holistically addresses the recommendations found in the report on the First Nations task force on LHINs dated November 2005. In this way, the bilateral process will achieve joint ownership and resolve the legal obligation and the duty to consult.

In closing, the Independent First Nations reiterate the significance of the report on the First Nations task force on LHINs dated November 2005, whereby the recommendations identified by the Independent First Nations echo an acceptable process by which legislative amendments to Bill 36 will facilitate the delivery of a health system mechanism that meets the special requirements of First Nations citizens.

On behalf of the Independent First Nations, I thank you for the opportunity to address the standing committee on social policy on Bill 36, the local health integration networks act.

The Chair: Thank you, Chief. Less than two minutes. Ms. Wynne, one minute.

Ms. Wynne: Thank you very much for being here this morning. I just wanted to clarify that you have been part of the dialogue with the Minister of Health on this issue.

Chief Nadjiwan: Yes.

Ms. Wynne: You've been involved, so the recommendations in that report are what he has before him and on which we're assuming the amendments will be based. So thank you very much for taking part in that dialogue and thank you for coming here today.

Chief Nadjiwan: Yes, and of course we remain available for any additional discussion or research material that may be required.

Ms. Wynne: Thank you.

The Chair: Mr. Prue.

Mr. Prue: Just a question so I can clarify here. The Chippewas of Nawash are primarily in the Manitoulin area and around?

Chief Nadjiwan: Just up on the Bruce Peninsula.

Mr. Prue: And you have been part of the process. How many other First Nations groups were part of the process, or did you meet independently? Did you meet one on one with the minister or did you meet in a group with other First Nations?

Chief Nadjiwan: It has been with a group.

Mr. Prue: How many First Nation groups were involved?

Chief Nadjiwan: I believe there was representation from the political and territorial organizations. So that would be perhaps a delegate from Treaty 9, Treaty 3, the Union of Ontario Indians, which I think did a presentation earlier, the Independent First Nations and the Association of Iroquois and Allied Indians. That would encompass most of the First Nation groups in Ontario.

The Chair: Thank you very much for your presentation.

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ARTHRITIS SOCIETY, ONTARIO DIVISION

The Chair: We will hear from the Arthritis Society. Whenever you are ready, you can start your presentation.

Ms. Jo-Anne Sobie: Thank you, Chair, and good morning. My name is Jo-Anne Sobie, and I'm the executive director for the Arthritis Society, Ontario division. I'll be sharing my time today with Kathryn Chambers, an arthritis consumer and volunteer.

To begin, I'd like to thank the committee for the opportunity to share the Arthritis Society's thoughts on Bill 36 and how it has the potential to impact on our ability to continue to provide specialized care and treatment to arthritis patients throughout Ontario.

To provide some context for my remarks, it is important to know that arthritis is the leading cause of morbidity and disability in our population, affecting 1.6 million Ontarians. According to the most recent statistics, two thirds of people with arthritis are women and nearly three out of every five people with arthritis are younger than 65 years of age, while one in five is younger than 45.

The Arthritis Society is the leading charitable organization dedicated to providing and to promoting arthritis education, community support and research-based solutions to those 1.6 million Ontarians living with arthritis. Reaching close to 150,000 Ontarians every year, the Arthritis Society employs a multidisciplinary and integrated team of occupational and physiotherapists, social workers, managers and program support staff. Add to this over 400 program delivery volunteers, and the Arthritis Society is capable of addressing many of the needs of arthritis patients in 98% of Ontario.

For over 50 years, the Arthritis Society has been partnering with the Ministry of Health and Long-Term Care to deliver the arthritis rehabilitation and education program. As a community-based rehabilitation program, it

specializes in patients who are more chronic and severely disabled than the average population, with a larger number of co-morbidities.

The Arthritis Society's continued capability to provide this highly specialized program is based on its ability to apply its resources flexibly throughout the province. This can only be achieved by having the ability to apply central resources where necessary.

In underserved areas, where need or cost cannot justify permanent staffing, meeting the need requires applying resources from other regions and partnering with external organizations. If the Arthritis Society is required to sign service agreements with the 14 LHINs, the ability to continue to provide care in underserved areas will be significantly limited and, in some instances, eliminated.

The flexibility and adaptability of a centrally funded program is necessary to ensure that the Arthritis Society is able to continue to respond to the needs of arthritis patients throughout Ontario.

The Arthritis Society also feels that the charitable health care providers need to be identified as preferred service providers within the LHIN structure. The ability to apply donor dollars and volunteer resources to augment the delivery of government health programs provides valuable additional care and treatment that otherwise would require the implementation of supplementary cost-based programs. This value-added component is unique to the charitable health care sector.

Through the generous support of donors, the Arthritis Society is able to provide programs and services like our website, our 1-800 information line, our arthritis self-management program, educational forums and public educational displays.

The professional services supplied by therapists and social workers, as well as the donor-funded programs and services provided by the society, make up an integral part of the support team that is helping Ontarians live with arthritis and to better manage their health.

As we move forward in the implementation of the LHINs, the care and treatment of chronic diseases like arthritis must receive a priority focus. The effective treatment of arthritis requires access to care as close to home as possible. The Arthritis Society's rehabilitation and education program is designed to be delivered in a truly community-based setting: in our homes, workplaces, neighbourhoods and community centres. It must remain a priority of the LHINs to ensure that chronic disease management can be accessed by patients in the communities where they live and work, not where hospitals and centralized resources are located.

A provincial strategy for the care and treatment of arthritis will ensure that equal access and treatment is available for all Ontarians. This will work more effectively to address the cost burdens and inequities that prevent care and treatment in many areas. The ability to provide central funding for provincial programs will aid in the implementation of a provincial strategy for arthritis care and treatment in Ontario. Without a provincial

strategy for people with arthritis, the access standards across Ontario will remain inequitable.

Before I turn it over to Kathryn, I would like to say that the Arthritis Society strongly supports the transformation of the health care system in Ontario. The leadership from this government and minister has put us on a path that, with careful consideration, will achieve a better health care system for all Ontarians.

I would now like to ask Kathryn Chambers to share with the committee her personal experience as a person living with arthritis. Kathryn is not only a client of the Arthritis Society but also a hard-working and valued volunteer.

Ms. Kathryn Chambers: Thank you, Jo-Anne, and good morning. I would like to thank the committee for this opportunity to speak on Bill 36. I'm here today to provide a first-hand account of the importance of the work of the Arthritis Society and the need to ensure that the arthritis rehabilitation and education program can continue.

I can recall as a child hearing about the important work of the Arthritis Society. My father was actively involved in an organization that helped raise money for the Arthritis Society every year, money that he said supported important programs that help people and their families to improve the quality of their lives while living with arthritis.

Not once did I expect to be the recipient of these programs. Throughout my life I had committed to living a very active, healthy lifestyle that included riding my bicycle around Toronto as my favourite mode of transportation. It included swimming regularly, hiking and canoeing through Algonquin Park and tending to a community garden, all while working as a health professional in a busy downtown hospital.

In 2001, I began to deteriorate rapidly, to the point of being bedridden. It took all of the strength I had to get to work, let alone tending to sick patients in a busy downtown hospital. My career was slipping away from me. When I was finally diagnosed with a rare inflammatory arthritis in acute onset, I found myself accessing the services of the organization my father had spent so many years raising money to support. I was extremely grateful to reach someone at the Arthritis Society's 1-800 information line. I didn't know what to expect, really, just that according to the society's website, this was somewhere I could get more information about my disease as well as access peer support.

The information line volunteer that I contacted quickly forwarded to me relevant information about my form of arthritis and also connected me with the Arthritis Society's arthritis self-management program. I knew that this program was for me, since I was fiercely independent, and I felt that if I educated myself, I could move past this.

With pain and fatigue commanding my days, I met others in similar situations. I realized that many of the emotions I was feeling were completely normal. The arthritis self-management program taught me to set

reasonable expectations, conserve my energy and helped raise my awareness of the various tools that reduce the load on joints. It also included meditation techniques and medication options. For the first time, I felt like I was taking an active role in my recovery from this disease.

Just after registering for the arthritis self-management program, I received a call from an Arthritis Society physiotherapist associated with my disease-specific peer group. There was an educational forum sponsored by the group to be held the next day. She made sure that I had transportation to attend. I met individuals coping with the same disease, and I became a member in a heartbeat. Many of these people have been inspirations to me as my journey continues.

Further support included a referral to the arthritis rehabilitation and education program. I met with an occupational therapist who was knowledgeable about the specific arthritis that I had. She not only gave me support through my insecurities and fears about the future, but assisted in the evaluation and adjustment of my home to allow for more gentle functional approaches to daily living. The physiotherapist was able to teach me disease-specific exercises and stretches and encouraged me to join a pool program. Even on days when every inch of my body screams with pain, floating buoyant lets me forget the hot spots all over my body.

The social worker helped with the emotional and logistical side of job loss. I had no idea what the future held, and she helped me to come to terms with this reality. Not only was I fatigued by the unceasing pain, but I knew my world had changed forever. My personal goals, hopes and dreams were put on hold or abandoned entirely.

As I began to feel a bit more comfortable with my situation, I needed to feel productive. The Arthritis Society offered me an opportunity to do this. That very same information line would be a source of comfort again, where I could use my medical knowledge, my experience and my desire to help others as a volunteer.

I am thankful to the Arthritis Society for the treatment, support and education that I received, and to my father for helping to leave this legacy for me when I need it most.

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The Vice-Chair (Mr. Khalil Ramal): Thank you very much. We have about four minutes left. We can divide them equally between two sides. Mr. Fonseca.

Mr. Fonseca: Jo-Anne, nice to see you again. Thanks to the Arthritis Society, and to Kathryn, for your own personal experiences with arthritis.

Through the LHINs, many presenters have talked about the regional disparity that exists in Ontario and the silo type of system that we have today. For a group like yours, wanting to meet with a community centre, wanting to be part of the hospital and address many of the hoops that the patient has to jump through to get the services that we've just heard about right now, would the LHIN model help in addressing that? Also, would we be able to

take those best practices that you may have in a particular community and deliver those across the province?

Ms. Sobie: Absolutely. I think there's every opportunity, and in fact we've already begun to engage very significantly in all of the LHINs across Ontario. We have already been working, and you mentioned that we are very much a community integrator to begin with. We work very closely at many levels with the government to try to ensure that best practice in arthritis care and treatment has been identified and is being disseminated, and we continue to work with centres of excellence, like the new Holland centre, and some of the other programs that are there. We have indeed developed our own best practice programs. Our Getting a Grip on Arthritis project, which is a community primary care provider education program, is an example of that.

We're quite comfortable working within a LHIN environment for planning. Where our biggest concern comes is because it requires critical mass at a provincial level with this highly specialized—keep in mind, there are over 100 forms of arthritis. We know osteoarthritis and rheumatoid are the most common. For the most part, people with osteoarthritis may very well be served in a much more LHIN-focused environment. For people who have extremely rare forms of arthritis that are extremely debilitating, it is very difficult to get referrals into support services, into specialized services. This is one of the critical pieces that, if we were required to provide those services separated in 14 LHINs, there aren't enough specialists to do that.

Being able to work in a community environment, but with a central specialized focus where we can then apply the resources at the best ability we have, working in between academic centres of excellence and community doctors, organizations, CCACs, is what we do best. We've done it for over 50 years. We would like to continue to do that.

The Chair: Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you for the presentation as well. I am going to point 3, which says that arthritis care and treatment requires a provincial strategy, which is what you were focusing on. What does the government need to do to ensure that? From your perspective, given that this legislation is also on the table, what signal, what work, what concrete actions does the government have to take to ensure that that's put in place?

Ms. Sobie: We're asking the government to identify arthritis once and for all as a priority disease in this province and to make it a strategy. This will allow us to work much more effectively at the civil service level with the Ministry of Health staff in coordinating those services and having an ability with those staff to bring the right people together to make the decisions.

One of the things that we've always suggested is that, yes, we know there are capacity issues, but we very much believe there's a huge opportunity through better co-ordination of current services in arthritis management, care and prevention to get a lot more out of it. But with-

out a strategy, arthritis continues to be addressed in its pieces. We have a huge priority on the government's part for total joint replacement. This is an end-stage treatment for arthritis. There is much more we can do and are beginning to do to address this disease in a more holistic way.

Calling it a strategy, providing the ability for staff in the Ministry of Health and in health promotion to address this disease as a whole and not just in hospital is absolutely critical to moving this forward. Thank you.

The Vice-Chair: Thank you very much for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 79

The Vice-Chair: Now we invite the Canadian Union of Public Employees, Local 79. I believe the president, Ms. Dembinski, is here, and I believe there is somebody is with you. State your name, please.

Mr. Tim Maguire: Tim Maguire. I'm the second vice-president and chief steward.

The Vice-Chair: Thank you very much. When you're ready, you can start. You have 15 minutes. You can use it all for your deputation or you can divide it between questions and answers.

Ms. Ann Dembinski: Thank you for the opportunity to speak to you today. I just wanted to tell you a little bit about CUPE Local 79. We represent city of Toronto workers, Bridgepoint hospital members and also the Toronto Community Housing Corp. We are the largest municipal local in Canada, with 18,000 members, and probably the largest local anywhere in Canada outside of even the municipal field. Some of the areas we work in are homes for the aged, public health, social services, parks and recreation, housing and court services. We are hospital workers, long-term-care workers, RNs, public health nurses, child care workers, city planners, ambulance dispatchers, etc.

We're here today to speak to you about this legislation. The stated purpose of this legislation, according to the act, is "to provide for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care and effective and efficient management of the health system at the local level by local health integration networks."

In the preamble, the act states that the government is "establishing local health integration networks to achieve an integrated health system and enable local communities to make decisions about their local health systems."

CUPE Local 79 will always support any measure that truly enhances and improves the delivery of health care services within a public, not-for-profit health system. However, we have a number of concerns about the proposed Bill 36. We question whether the proposed legislation will ensure that the stated intentions are fulfilled, or will Bill 36 in fact hinder the declared purposes?

The boundaries for the local health integration networks governing the city of Toronto health care facilities defy all logic. The configuration of the LHIN boundaries means that Toronto is served by five LHINs. Only one LHIN is totally contained within the municipal boundaries. The city of Toronto's 10 homes for the aged and related services will report to five separate bodies for planning and funding purposes. Each of the city's homes for the aged has already developed critical linkages and work relationships with health, social service and community partners. These relationships have strengthened the care and service the homes provide. For example, at present, a municipal home for the aged in the far west end of the city may collaborate with a downtown hospital for purposes of providing a particular type of program. In the new configuration, the hospital and the home would be in different LHINs.

The homes for the aged are already fully integrated with their local communities and have strong historic relationships with them. The consequences of dividing Toronto among several LHINs will mean not only a loss of accountability to the respective communities currently served, but also to the city of Toronto within whose municipal boundaries all these homes are located.

The city of Toronto is a unified community already doing what the LHINs advocate. The city of Toronto accurately determines community needs and priorities and recognizes the diversity of interests and communities. The city of Toronto is accountable to the communities it serves and has developed effective community engagement mechanisms. The city of Toronto builds on the successes of existing coordinating networks and accumulated knowledge to coordinate health and social services into a coherent system.

Some of these LHINs cover only limited portions of the city and include substantial portions of suburban and rural areas surrounding the city. This raises the distinct possibility for integration decisions being made by LHINs whose composition is not city-friendly and whose orientation is suburban or rural. These LHINs will have little to no understanding of the specific and unique needs of our richly diverse communities, including multilingual needs.

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It is conceivable that CUPE Local 79's membership might be dispersed and integrated into service providers whose primary focus is outside of the city of Toronto, controlled by employers whose head offices are located outside of the city. It's possible that these for-profit service providers could be from outside of Canada. CUPE Local 79 is not alone in these concerns about the jurisdictional structure of the LHIN boundaries. We've heard that there has been similar apprehension voiced throughout Ontario.

The impact of Bill 36 on our members—I just wanted to speak about this. Local 79 has made several presentations recently on the proposed OMERS legislation, and it almost seems that I'm here more than I am at city council. That's really quite alarming, when I'm spending

my days up here. Certainly, I can tell you that's not what our members expected, to see me up here all the time, fighting this government on their behalf.

We highlighted during the OMERS presentation the inequitable situations created by the legislation which would affect our members, especially those earning modest wages. Many of these members work in homes for the aged and at Bridgepoint hospital. The majority are women. A significant number of them are also women of colour. This government is again jeopardizing our members who work in the homes for the aged, and now our members who work at Bridgepoint hospital, this time by creating five different LHINs.

The impact of Bill 36 on our members will be severe as well as disruptive. Bill 36 allows bargaining units to be combined and forces the seniority among separate bargaining units to be merged. This is accomplished by the power and discretion of the Public Sector Labour Relations Transition Act.

Local 79, better than anyone, understands the seriousness of labour-force impacts from its experience with the amalgamation of the city of Toronto. I see Mr. Balkissoon sitting here. He dealt with it. You were there when the chaos was created. That process has certainly been one of the most chaotic things we've ever seen. I think Kathleen Wynne was a community leader at that time, who, along with John Sewell, was very vocal about the damage that amalgamation would do to Toronto. I can say that Local 79 and the city of Toronto have not yet, eight years after amalgamation, sorted through all the issues of amalgamation. We urge this government to consider the experience that the city of Toronto had as it moves to finalize Bill 36.

I want to just talk a bit about the new city of Toronto act, which states: "The purpose of this act is to create a framework of broad powers for the city which balances the interests of the province and the city and which recognizes that the city must be able to do the following things in order to provide good government:

"(1) Determine what is in the public interest for the city.

"(2) Respond to the needs of the city.

"(3) Determine the appropriate structure for governing the city.

"(4) Ensure that the city is accountable to the public ..."

There are others.

"The assembly recognizes that the city is a government that is capable of exercising its powers in a responsible and accountable fashion.

"The assembly recognizes that it is in the interests of the province that the city be given these powers."

The proposed legislation removes Toronto's ability to plan and deliver the city-operated and funded health services that are included in the LHIN legislation. Toronto's power as a government is being severely eroded by Bill 36. Again, this government is creating jurisdictional chaos with the LHIN boundaries.

CUPE Local 79 strongly supports the city of Toronto's recommendation for the development of one LHIN, city-wide. If this model is not possible, we would support the city's position that the legislation contain clear authority to prescribe a five-LHIN/city of Toronto collaborative table, composed of equal representation from all five LHINs and Toronto to ensure joint decision-making about those services currently included in the LHINs legislation that are operated by, or receive funding from, the city.

Without going into great detail, because I could, we again question why there are two sets of rules: one for not-for-profits and one for profit-making entities. There are many questions we could ask about that. It's not difficult to see a shrinking set of non-profit providers while the for-profits continue to gain new market opportunities as the system is restructured in this way. The proposed legislation will significantly alter the playing field from an unfair system, which already favours for-profit providers, to the two-tiered system that the government always denies it is advancing.

CUPE Local 79 strongly opposes privatization of health care services, competitive bidding and contracting out. We believe this legislation promotes privatization in several ways and facilitates the spread of competitive bidding throughout the hospital system. The LHINs may move funding, services, employees and some properties from non-profit to for-profits. Cabinet may order the wholesale privatization or contracting out of all support services in hospitals.

CUPE Local 79 members work in Bridgepoint hospital, which is Canada's largest and most extensive integrated health care organization for specialized complex care services: complex rehabilitation, complex care, long-term care and community-based care. Bridgepoint provides a continuum of care that links different services and facilities to ensure that people receive the right and best type of care at the right time.

There is nothing in Bill 36 to prevent services in Bridgepoint from being contracted out to private sector providers. The government has given itself the power to define who is a service provider—

The Vice-Chair: Excuse me, you have one minute left, if you want to conclude.

Ms. Dembinski: CUPE Local 79 urges you to give careful consideration and attention to our concerns and requirements. Again, we'll state that we think the proposed legislation must be amended to revise the boundaries for the LHINs.

The Vice-Chair: Thank you very much for your presentation.

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CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 2191

The Vice-Chair: Now we'll call on the second group, the Canadian Union of Public Employees, Local 2191,

Toronto; Fred Hahn, president. Welcome. Mr. President, you can start at any time.

Mr. Fred Hahn: I know there are only 15 minutes, so I'm going to try to be as brief as possible. I will tell you a little bit about myself. I'm the president of a local union of just over 1,000 social service workers here in the city of Toronto. I am here on behalf of our members, not on behalf of the employer. The agency we work for is Community Living Toronto; it's an agency funded by the Ministry of Community and Social Services. We support well over 5,000 people with intellectual disabilities and their families in Toronto. I want to try to emphasize some of the concerns we have not only as community members and workers, but also as advocates for people with disabilities in the community, because for our members it's impossible to separate those things.

I'm going to try not to repeat some of the things I know you've heard, not only today but in other presentations, and hopefully allow some time for questions, and actually some questions that I have as well.

In terms of community input and control, our members work for a community-based agency that is controlled by a board that is elected, which represents people who receive services and people who are concerned community members. In fact, our agency in the city of Toronto recognizes that the city itself is actually too large to provide real community control. We have four regions in the four old cities that also have elected councils that also do that kind of democratic leadership and advocacy. What we're concerned about in this legislation, the way we read it, is that LHIN boards not only are not elected, but are not accountable to people in the communities. By legislation, they're only accountable to the Minister of Health. We also believe, of course, that there has to be a consultative structure put in place in terms of real community input, and there is nothing in the current legislation that would imagine that in a structured way.

We've heard a lot about the geographic concerns about the LHINs in Toronto. Residents in Toronto will have five different LHINs. For workers in our agency who help people with disabilities to access health care, our concern is that there really isn't anything that clearly articulates, in the legislation, that each particular LHIN in the city will have the same kind of service and the same kind of access to those services. For example, it seems conceivable that user fees might be introduced in one LHIN and not in another. If we're assisting people with disabilities who require assistance to access health care services, there are, as you might well imagine, working in the same city, huge concerns that we might have. As well, currently, people whom we support can go to one place and get a series of supports in one location. We're not sure—I don't think anyone is—what the results of the legislation might be in terms of creating centres of excellence, of specialization. Does that mean we will have to assist people with disabilities to go to five and six different locations, when now they are served and supported by one?

Basically, we're concerned about what we perceive, at least what our membership perceives, as a real lack of

consultation in relation to the structure of the legislation. It seems to us that the current government never ran on this when they were being elected by the people of Ontario. It was never part of any policy or any platform, and it's our view that people didn't actually vote for this. Sure, governments have to govern while they're elected, but in our view, let's have a real consultation before introducing something that could vastly change the way in which health care is delivered.

There is also, it seems to us, quite a hurry. The legislation was introduced during the midst of a federal election, second reading happened just before Christmas, and here we are with third reading. It seems quite fast, considering a huge amount of change is possible and imagined by the legislation. We believe, and think that many of you believe, that public consultation is the cornerstone of good public policy. That's what these hearings, of course, are for. But many of us have 15 minutes to talk about a variety of concerns, and it is really a challenge to do that. So we would hope that part of what you may recommend is that there be a more extensive consultation process entered into so that people can actually be more aware and more involved in this discussion.

One of the things we discovered, talking with our members—well over 1,000 of them, as we said, well plugged into the community and their communities in Toronto—was that many of them had no idea that the LHINs existed, that the legislation existed and what potentially it meant. We entered into a discussion with them that was in many ways an education process. We feel that our members represent the public and that if our members didn't know about it, then many people in the public don't know about it, and there are a lot of changes being proposed here that people might not know are coming.

We're concerned, and you've heard from lots of people, that the legislation may enable privatization. There is nowhere in the bill that we can see in reviewing it that ensures, requires or even encourages the Ministry of Health or the cabinet to preserve the public, not-for-profit character of the health care system. We think this has to be absolutely, clearly defined in the bill. Talking about whether or not a particular service would be delisted, that kind of stuff, is quite a narrow definition of privatization. What we're quite concerned about is moving, wholesale, huge chunks of the health care system out to the private sector.

We've seen that in home care. There has been a lot of discussion about the possibility. While it's not clearly articulated in the bill, it seems clear to us that it opens the door to competitive bidding. If the minister is clear, as he seems to have been in the media recently, that this is not the intention, then why not put it in the bill? Why not just say that there will be no competitive bidding model, that there will be strong efforts to maintain the public, not-for-profit nature of the health care system in Ontario? Why not just be clear about that in legislation?

Of course, there is the potential for labour unrest. You've heard about that in the previous presentation and

in many other presentations. In fact, you have heard from a number of local unions, health care workers and other parts of the trade union movement, but also from community groups and others, who are concerned that there may be, with the way that the legislation could be enacted and its impact on representation votes and bargaining units, the potential for the legislation to actually overstep negotiated collective agreements. Surely anyone in this room, each and every one of you in this room, would understand that the response that might generate would not be a healthy or helpful one. What we're suggesting is that there be real consultation to ensure that that kind of labour unrest doesn't happen.

Part of what is most concerning for our members is that those of us who have come forward to the committee have been accused of fearmongering, of using rhetoric. Of some of the concerns we have voiced it's been said that there's no research, that they're baseless. In fact, that isn't true; there's a lot of research. I could spend the whole day with you—I wish I could, but I've only got 15 minutes—articulating the things that I've learned in a very short period of time. I feel that there is a great deal of research, a great deal of concern, not just from unions but from health coalitions, community partners, employers, health care providers and community-based agencies. It seems to me and to our members that it would be good public policy to listen to the vast majority of people who have come before this committee and to say, "Look, there are some real concerns here." If it is not the intention of the government to encourage privatization, to cause labour unrest, to cause havoc in the health care system, then let's slow the process down. Why not enter into a more protracted kind of real consultation with stakeholders and a real consensus built to restructure health care in a way that will help people and workers in the province of Ontario?

The last thing I wanted to say is that we have also been, it seems, accused of not having any good ideas, of just wanting the status quo. Part of the trouble is that it's really hard to come up with an alternative in 15 minutes when you're responding to a piece of legislation which, quite frankly, has all kinds of things in it; any one of us could spend 15 minutes talking about just one piece. It seems to us that labour unions have talked about many good ideas, like a provincial benefits plan, for example, a way of saving money for workers across the system. That idea hasn't been picked up or talked about. Sometimes it feels to those of us in the system like we propose ideas that could actually cause efficiencies and they're not picked up or listened to.

Again, what our members—over a thousand of them—asked me to do was to come here on their behalf and say that we think the process needs to be opened up, slowed down. We urge the committee to strongly recommend to the Minister of Health and to the government that the current bill be set aside and that we have a fuller consultation with local communities, health care workers and the public about how health care can actually be transformed in a way that will be helpful, in a way that

will be more inclusive and satisfactory, and in a way that will guarantee the public nature of our health care system. Thanks.

The Vice-Chair: We have four minutes, to be divided equally among the three parties. We're going to start with Ms. Martel.

Ms. Martel: Thank you for your presentation today. I'm going to focus on page 5, "Privatization enabled by legislation." You say in your remarks, "There are no provisions in the bill—anywhere"—that's highlighted—"that ensure, require or even encourage the Minister of Health ... to preserve the public, not-for-profit character of our health care system." You are correct: There's nothing in the preamble that references trying to maintain that not-for-profit character of the system. There's nothing in the objectives of the LHINs that would point that out. Nowhere does it say that that's what the point of the matter is, that in any change that's going to take place we are indeed not only going to preserve and protect but enhance the not-for-profit nature. Given that the bill doesn't seem to say anything, what would you like to see in this regard so that if the minister really means that, we might actually have it in the legislation?

Mr. Hahn: We think it would be important to embed in the legislation a clear commitment to preserve public, not-for-profit health care. It should be clear that there would be no competitive bidding model that would be used in the LHINs. That should be clearly articulated in the legislation. In fact, it seems, based on reading the papers, that the Minister of Health himself has said that's not the intent, so why not just be clear about it?

What we think should happen also is that there be a requirement that before developing any provincial strategic plan like section 14 of the bill talks about, there would be a province-wide consultation on the appropriate funding formula in a LHIN and for any of the subsector health service providers in the LHIN. We also think that section 28, which I know you've heard a great deal about, needs to be withdrawn from the legislation to make it fair and clear.

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Ms. Martel: And perhaps we should put the principles of the Canada Health Act somewhere in the bill too, while we're at it, in the preamble or in the objectives; that the work of the LHIN should be to support, maintain and enhance the principles of the Canada Health Act.

Mr. Hahn: That would make perfect sense.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being here today. I just wanted to pick up on the consultation issue for a second. You talked about the need for more consultation. The minister began, in 2004, to talk about this idea with various groups. We had the town hall consultations. So 4,000 individuals and groups were part of that. We've had seven days of hearings, well over 200 groups have come before us, and I guess the thing for me that is the most important is that embedded in the bill is a provision for ongoing consultation, because this is an iterative process. This is not a framework that is going to

be put in place and then is forevermore that thing. There are going to be discussions about the plans. There is going to be an engagement process. Section 16 is all about that. I know there will be amendments that will come forward to expand on the specificity of section 16. So I guess I'd like your comment on just how much more consultation could be done, and I'd especially like your comment on the part of the bill that lays out that need for ongoing community engagement. Is that not a good thing?

Mr. Hahn: Of course it should be in the bill that there would be ongoing community consultation.

Ms. Wynne: But it is.

Mr. Hahn: What seems unclear is that a LHIN and its directors, who aren't elected by that community and aren't clearly accountable in any way because they're not elected by that community, can actually declare that whole parts of their meetings aren't open to the public, and that any decision they make can be appealed but only within 30 days and there's only one right of appeal.

Part of the discussions the minister has had around the province on the options around health care—right now there is a structure, a concrete thing that's being proposed. It seems to our members that the majority of the people who have come forward are expressing concerns about that particular structure and the ways in which it is being particularly proposed and some particular holes that may be in there.

Naturally, whatever system is there, we think it would be important to have ongoing, open and full consultation that also takes into account all stakeholders: the public, but also people who work in the health care system because those people are experts. They provide the services. They are, in fact, health care heroes, as we knew during the SARS outbreak here in Toronto. So it's important to build that in. It's not clear in the legislation that that will actually be there and it's not clear in our members' minds that even in the outgoing consultation that the minister did for the last year or so, these particular provisions were going to be what we may be dealing with.

So I think what we're trying to say is, now that we have something concrete that we can look at and say, "Here are some concerns and problems and issues," instead of making this law, because we all know that once something is law it becomes even harder to change it, why not slow down the process? Make it better, make it so that more people feel like they can support it. Then make it law—and build in consultation, absolutely. What's the rush? What's the hurry?

The Chair: Thank you very much. Mr. Miller.

Mr. Miller: Thank you for your presentation. You have a section in your presentation to do with the makeup of the LHINs in Toronto. I know the LHINs, in theory, are supposed to be based on referral patterns, although it does seem a little strange to have five separate LHINs for the Toronto area. Do you have recommendations on how many LHINs you think there should be in the province, and specifically for the Toronto area?

Mr. Hahn: What we included was the motion from the city of Toronto, and the previous speaker and the city have talked about importance of having one LHIN for the city. It seems to us that Toronto may be the only city that's broken up in this way, based on the proposed boundaries. So I think it presents a particular challenge for Toronto and I think it makes sense for all of the health care provision in a city to be incorporated in one geographic LHIN.

Mr. Miller: Very good. Your comment about the makeup of the board members of the LHINs—elected versus appointed. Obviously the government has decided to go with appointed members. Can you see an advantage, in terms of health outcomes, to having appointed members, or what's the problem, I guess I would ask you, to do with having elected members?

Mr. Hahn: We don't think there would be a problem with having people elected. We actually think it would be important to have people elected. The thing about being appointed is that it's unclear to us what accountability there is back to the community. The whole idea, based on what I've been reading and what the minister is saying, is that this about localizing health care, localizing control. But if the people in a community or an area have no way of picking the people who will represent them, then what's the accountability if the legislation says those people are only accountable to the Minister of Health? And why not let MPPs from the LHINs be ex-officio members of the LHINs, so that there's some accountability to the public though MPPs?

The Chair: Thank you very much for your presentation.

CANADIAN UNION
OF PUBLIC EMPLOYEES,
TORONTO REHABILITATION
INSTITUTE EMPLOYEES

The Chair: We now go to the next presentation, the Canadian Union of Public Employees, Toronto rehab hospital employees; Paul MacDonald. Good morning, Mr. MacDonald. You can start any time you're ready; 15 minutes total.

Mr. Paul MacDonald: Good morning, everyone. Good morning, ladies and gentlemen of the committee. My name is Paul MacDonald. I'm here today as a concerned provider of direct patient care in our currently public health care system. As vice-president of our union local, representing over 200 dedicated and caring members at five sites that make up the Toronto Rehabilitation Institute, this is my second time before a committee here regarding an attack on the providers of health care at our facility and many others across this vast province, the last time regarding contentious aspects of Bill 8. Our health care members, both unionized and non, have many concerns regarding aspects of this bill, and here are just a few that I'd like to present.

I guess I would start with the concern of centralization of health care services. The LHINs are local in name

only. The bill would grant little real power to local communities and providers to make decisions. Rather, it transfers control over local, community-based providers to the minister and cabinet and to their agents, the LHINs, thereby centralizing rather than localizing control over health care and certain social services in Ontario. The bill grants unprecedented authority to the Minister of Health and cabinet to effectively control most public health care service providers and to completely restructure public health care delivery, including the power to turn delivery over to for-profit corporations.

Community control and provincial government accountability: The LHINs cover vast and very diverse areas. The LHIN boundaries have been formed based on hospital referral patterns, overriding municipal, provincial and social boundaries. The proposed LHINs are not local, they are not based on communities and they do not represent communities of interest. As a result, they lack political coherence. Example: LHIN 9 goes from Toronto practically to the border of Algonquin park. It will be very difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN, even if the LHIN board wishes to listen.

The autonomy of the LHINs from the government is very modest. With this bill, cabinet may create, amalgamate or dissolve a LHIN. A LHIN is defined as an agent of the crown and acts on behalf of the government. LHINs are governed by a board of directors appointed by cabinet and paid at a level determined by cabinet. The government determines who will be the chair and vice-chair of those boards. Each member continues on the board at the pleasure of the cabinet and may be removed at any time without cause. Each board member will make about \$350,000 in salary and then they get \$350 per meeting. Elected members on hospital boards are voluntary.

LHINs boards will be responsible to the government rather than local communities. This is in contrast with the long history of health care and social service organizations in Ontario, which as a rule are not appointed by the provincial government; for example, hospitals. They have doggedly pointed out the need for better care in their communities with significant success. Recently, however, the government has found a way to blunt criticism of underfunding and privatization. The key was to replace community boards with government-controlled boards. This, unfortunately, is the model for LHINs. The result of this experiment in community care access centres suggests that this is a very poor model for LHINs to follow.

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Next I'd like to focus on service cuts. The government plan is to regionalize hospital support services. With government support from Ontario Buys, dozens of hospitals across the north are planning to consolidate supply chain and office services by turning work over to a new employer, Northern Ontario Hospital Business Services. Likewise, with government support, 14 hospitals in the greater Toronto area plan to regionalize

supply chain and office services by turning work over to another new organization, Hospital Business Services. This organization would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations and sever roughly 20% to 25% of existing employees, and more such plans are in the works.

Next I'd like to focus on clinical services threatened. By April 2005, the government admitted as much, with the health minister publicly calling for the centralization of hospital surgeries. Mr. Smitherman was on record as saying, "We don't need to do hip and knee surgery in 57 different hospitals." Instead, he suggested that about 20, i.e. a 60% cut, might be appropriate. He said, "Each hospital in Ontario will be given an opportunity to celebrate a very special mission ... but not necessarily operating with as broad a range of services as they're tending to right now." This squarely raises the prospect of even more travel for health care services.

The government has also begun to move surgeries right out of hospitals and place them in clinics. The first instance was the recent creation of the Kensington Eye Clinic. This clinic, in the recently closed Doctors Hospital in Toronto, is supposed to remove 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries. This, the ministry says, is only the beginning.

The creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to as they tend to their health care needs. It also raises the possibility of the establishment of for-profit surgical clinics. A better solution would be to create surgical clinics in the facilities and organizations in which we are already invested. Hospitals have the infrastructure needed to support these surgical clinics. There is no need to duplicate their human resources, stores, payroll, purchasing, cleaning, food, lab and other support services. Hospitals also have the resources to deal with emergencies that may occur during operations. And this would actually help advance the seamless care that this reform is supposed to create.

I'd like to focus on the impact on bargaining units. The change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements and collective bargaining. The bill would extend the coverage of the Public Sector Labour Relations Transition Act, 1997, to many of the potential changes in employment that could result. We are not convinced that the government fully recognizes the can of worms it is opening. As the workers faced with this change, we deserve, at a minimum, a fair process that will provide reasonable employment security and protect working conditions, collective agreements and bargaining unit rights.

CUPE is closely examining the impact that Bill 36 and its use, in some cases, of the Public Sector Labour Relations Transition Act to deal with the labour relations issues raised. But we can note that we are concerned that the Public Sector Labour Relations Transition Act may

not be applicable in cases where the entity receiving the work is not a health service provider and where the primary function of that entity is not the provision of services within the health sector. This may allow LHINs or government to transfer work without providing health care workers with the right to a union representation vote. We would also like to make crystal clear that the employment security protections of our collective agreements cannot be overridden by this bill, and we propose to protect bargaining unit and employment security rights.

Suggestions:

(1) Provide in the bill that the Public Sector Labour Relations Transition Act applies regardless of whether a person or entity is a health service provider, and regardless of whether the primary function of the person or entity is to provide services in the health sector.

(2) Remove from the bill the proposed cabinet authority to exempt application of the Public Sector Labour Relations Transition Act.

(3) Provide that nothing in Bill 36 or the application of the Public Sector Labour Relations Transition Act can have the effect of overriding negotiated employment security provisions.

The experience with competitive bidding in social services: Competitive bidding is also doing damage in social services with its introduction by Human Resources and Skills Development Canada. The new bidding process has, in the first round of proposals, disrupted over a third of the long-standing arrangements with community organizations. Three organizations are losing so much of their funding that they will have to close their doors. Four contracts have been awarded to the for-profit sector. Clients have no idea where they will be served, if at all, while the programs and linkages created over decades of work are being lost. Laid-off social service workers are being forced to re-apply for their same jobs at a lower rate of pay and benefits.

I'd like to read some summaries: The estimated cost to maintain the LHINs bureaucracy, an estimated 500 new bureaucrats added and not a single new care provider, is \$55 million annually; \$20 million to dismantle district health councils; and \$21 billion of an annual budget to be spent by LHINs.

In summary, LHINs will take services, mostly from hospitals, and have them delivered at a handful of sites located over huge geographic regions. LHINs will not align critical parts of the system not presently covered. LHINs will sharpen regional inequalities. LHINs fail to address the real drivers of health care costs: pharmaceuticals, CEO salaries, new technology and private sector entities currently in the health care system.

LHINs will create a large new bureaucracy. LHINs mean institutionalization chaos: no end to mergers, amalgamations, rationalization. LHINs open the door to more private sector for-profit delivery of health care. The ability of communities to influence which services are offered locally is diminished. LHINs threaten job security and put downward pressure on wages and benefits through competitive bidding.

I'd like to quote Ian Urquhart from the Toronto Star:

"What the government has in mind here is the consolidation of services now being offered in many hospitals in a region—say, cataract removals or hip replacements—into just one hospital or even a doctor-owned clinic...."

"Now, all this is fine provided you are not either a hospital employee ... forcibly transferred, or a patient who has to travel 100 kilometres for a routine procedure."

The Chair: Thank you. The time is—unless there are any other concluding comments, we thank you for your presentation.

ALLIANCE FRANCOPHONE DES RÉSEAUX DE SANTÉ

The Chair: The next presentation is from l'Alliance francophone des réseaux de santé. Bonjour, monsieur. Please start any time you're ready.

Mr. Denis Constantineau: Thank you. I have a brief presentation in French, and then if there are any questions—

The Chair: That's fine. Ça va.

M. Constantineau: Monsieur le Président, chers membres du comité, l'Alliance francophone des réseaux de santé est, par le biais de ses partenaires, le porte-parole provincial de la communauté francophone dans sa diversité en matière de santé en français.

Au cours des audiences précédentes, votre comité a entendu des représentants de la communauté franco-ontarienne partout dans la province, dont les représentants de nos quatre réseaux, exprimer leur vœu que la réforme majeure du système de santé de l'Ontario reflète une amélioration en profondeur des services de santé en français.

Vous les avez entendus vous décrire leurs réalités dans différentes régions de la province en ce qui touche l'accès à des services de santé en français, un accès qui dans plusieurs régions n'existe tout simplement pas ou très peu et qui s'est dangereusement détérioré ailleurs malgré l'adoption de la Loi sur les services en français et même dans des régions où vivent de fortes concentrations de francophones.

Votre comité a appris de plusieurs témoignages que la santé des Franco-Ontariens et des Franco-Ontariennes, à cause de ce manque d'accès, est moins bonne que celle de la majorité de la population de l'Ontario. Le manque d'accès a un impact négatif sur la santé des Franco-Ontariens, car il est démontré qu'ils attendent d'être plus malades avant d'avoir recours aux soins de santé, ce qui occasionne inévitablement une augmentation dans les coûts du système de santé. Il est inacceptable que l'on oblige nos francophones dans leurs plus grands moments de vulnérabilité à obtenir des services de santé dans une langue qui n'est pas la leur.

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L'application de la Loi sur les services en français par le ministère de la Santé et des Soins de longue durée a

été, sinon un échec total, à tout le moins très peu utile à assurer des soins de santé de qualité pour les francophones de la province. Cette sombre situation est principalement due à l'approche minimaliste du ministère face au maintien et au développement des services de santé en français.

Vous avez entendu des histoires d'horreur sur l'impact qu'ont ces politiques du ministère sur la façon avec laquelle sont traités les francophones dans notre système de santé. On pourrait vous entretenir pendant quelques journées d'audiences à vous en raconter d'autres. Des personnes âgées, des enfants, des unilingues francophones, et même des gens bilingues à leur plus vulnérable sont laissés pour compte.

Il n'y a aucun doute qu'à cause du manque de services de santé en français, les francophones occupent souvent des lits d'hôpitaux ou des bureaux de médecins plus longtemps que nécessaire, parfois beaucoup plus longtemps que nécessaire. Ça coûte de l'argent, et ça bloque le système de santé pour tous les Ontariens.

On vous a même dit que le simple fait d'être minoritaire francophone en Ontario est un déterminant social qui peut influencer sur la santé des minoritaires, au-delà de tous les autres déterminants sociaux. En d'autres mots, être Franco-Ontarien peut vous rendre malade.

On vous a renseignés sur l'étendue de nos droits constitutionnels et légaux, confirmés par plusieurs jugements de la Cour suprême du Canada et, spécifiquement en santé, par le jugement historique de la Cour d'appel de l'Ontario dans le cas de l'Hôpital Montfort. Ces droits se résument à deux principes fondamentaux :

Premièrement, aucun gouvernement au Canada n'a le droit de prendre des décisions qui encouragent, directement ou indirectement, l'assimilation des francophones minoritaires à la culture et à la langue de la majorité.

Deuxièmement—et ceci est particulièrement important dans le contexte de la réforme actuelle—plusieurs jugements de la Cour suprême ont confirmé que la minorité linguistique est la mieux habilitée à prendre les meilleures décisions pour les services offerts à la minorité. Faire le contraire ne représente pas une pratique exemplaire en santé.

Monsieur le Président, membres du comité, si vous n'y étiez pas déjà, vous êtes maintenant au courant de la situation de la francophonie ontarienne en santé, et parce que vous êtes maintenant au courant, vous en êtes aussi responsables. Nous respectons votre pouvoir de décider et d'agir, mais vous ne pouvez le faire dans l'ignorance des faits. Vous nous avez écoutés, et maintenant, vous devez nous démontrer concrètement dans vos décisions et vos actions que pour un gouvernement qui se préoccupe des siens, ça commence dans le système de santé.

Dans ce sens, il est probable que certains parmi vous subissent des pressions de la part de gens mal informés, résistants au changement, douteux de nos intentions réelles et, il faut le dire, d'une minorité carrément hostile et très vocale à tout ce qui est de langue française. Il est possible que ceci vous incite à entrevoir des épouvantails comme le « French backlash ».

Permettez-moi de dire deux choses là-dessus : premièrement, l'Ontario a changé. Notre population est très ouverte à la minorité francophone, et une majorité de la population de l'Ontario considère que la dualité linguistique est une valeur fondamentale du Canada, comme l'est aussi l'accès à des services de santé publics. Deuxièmement, les Franco-Ontariens et les Franco-Ontariennes ne craignent pas le ressac anglophone. Nous en avons trop vu, trop entendu pour avoir peur aujourd'hui.

À travers notre histoire, nous avons appris une chose extrêmement importante. La grande majorité des gens respectent deux qualités au-delà de toutes les autres chez leurs représentants politiques ou autres : l'intégrité et le courage. Le ministre de la Santé et des Soins de longue durée a fait preuve d'intégrité et de courage en impliquant pour la première fois les francophones dans une initiative majeure du ministère de la Santé.

Le groupe de travail présidé par M. Gerald Savoie a étudié toute cette question pendant presque une année en collaboration avec le ministère de la Santé. C'est sans précédent, et c'est d'une importance vitale. La communauté franco-ontarienne est impatiente de voir ce document rendu public, de même que la réponse du gouvernement à ses recommandations.

L'Alliance francophone des réseaux de santé a reçu le mandat de la communauté de présenter les amendements que nous aimerions voir dans le projet de loi 36 pour qu'il respecte les droits et réponde aux besoins et aux réalités de la communauté francophone. Nous respectons absolument le rôle des législateurs à formuler ces amendements. Par contre, nous déposons devant vous un compendium des principes importants que la communauté souhaite voir ajouter à la loi. Fondé sur le principe que le gouvernement et les ministres changent, il importe pour nous d'assurer la protection et la prise en compte de la situation de la minorité francophone à même le texte de la loi et de la réglementation qui y est associée dans l'éventualité d'un gouvernement futur moins ouvert à notre communauté.

En bref, nous voulons premièrement voir une modification au préambule de la loi reconnaissant le rôle des francophones dans la planification et la provision des services de santé en français au même type que les Premières nations et les autochtones;

—de même, un amendement spécifiant que l'intérêt public implique le respect et la protection constitutionnelle des minorités linguistiques;

—une autre modification permettant un dialogue continu et permanent entre la communauté francophone et le ministre de la Santé;

—de même, une provision assurant que les décisions qui touchent les services de santé en français sont prises au niveau local par les francophones, fondées sur le droit et sur le principe que la réforme du système de santé est centrée sur les communautés et sur le patient;

—en fin, les plans ministériels et locaux de services de santé devraient tenir compte des services de santé en français. Il est imputable dans ce sens.

Le système de santé de l'Ontario doit être imputable de l'argent des contribuables et nécessairement des services de santé en français : la meilleure, sinon la seule façon d'y parvenir et d'assurer une prise de décisions francophones pour les questions francophones.

Il n'est pas question de proposer un système de santé francophone séparé, parallèle au système dans son ensemble. Les services de santé en français doivent être totalement intégrés au système de santé de la province.

Monsieur le Président, l'Ontario est un carrefour crucial de son histoire en santé. C'est aussi un moment décisif pour sa communauté franco-ontarienne. L'Ontario a un rôle vital à jouer, non seulement au nom de la justice et l'équité sociale mais au nom de la confédération. L'Ontario, qui abrite plus d'un demi-million de francophones, soit la moitié de tous les francophones minoritaires au Canada, doit servir d'exemple. Nous ne pouvons nous permettre d'échouer; le prix pour tous les Ontariens et les Ontariennes est trop grand. Merci.

The Chair: Merci beaucoup, M. Constantineau. Thirty seconds each. M. Ramal, s'il vous plaît.

M. Ramal (London-Fanshawe): Merci, monsieur le Président. Merci pour votre présentation. Je pense maintenant au ministre de Santé parlant avec la communauté francophone, et travaillant pour établir un mécanisme spécial pour la communauté francophone de l'Ontario. On sait que tu as pensé bien à une méthode alternative pour la communauté.

M. Constantineau: C'est une excellente méthode. On parle du comité de travail de M. Gerald Savoie. Ce dialogue-là est très positif, et c'est quelque chose qu'on voudrait voir continuer tout le long du processus d'intégration, même après l'adoption de la loi, pour pouvoir sonder la population et aller voir quels sont les intérêts, les besoins en développement des services de santé en français. On recommande que ce mécanisme-là soit intégré à la loi pour que ça continue.

M. Ramal: Je pense maintenant au ministère—pour un changement d'un élément de la loi 36. Je pensais aux accommodations des besoins de la communauté francophone de l'Ontario. Maintenant, le ministre de la Santé travaille avec la communauté francophone pour changer cet élément de la loi 36.

M. Constantineau: Nous, on attend encore les propos du rapport Savoie, que le ministre a entre ses mains. On aurait espéré qu'il soit rendu public avant les audiences pour qu'on puisse prendre connaissance—évidemment, tout ça est un secret. Alors, on ne sait pas ce qui est recommandé par le groupe de travail Savoie, mais on est confiant, étant donné la représentation à ce comité-là, qu'ils ont l'appui de la communauté lorsqu'ils vont recommander au ministre de représenter vraiment les besoins de la communauté.

Le Président: Merci. M. Arnott, s'il vous plaît.

M. Arnott: Merci, monsieur le Président, et merci pour votre présentation.

The Chair: Thank you. M^{me} Martel, s'il vous plaît.

M^{me} Martel: Merci, M. Constantineau, pour être ici ce matin. Nous savons très clairement que M. Savoie et

d'autres personnes avaient fait un énorme travail à propos de la situation de santé de haute qualité pour les Franco-Ontariens.

Malheureusement, nous n'avons pas de recommandations devant le comité. Alors c'est bien difficile pour nous, comme comité, de faire face aux recommandations ou de proposer des amendements qui pourraient peut-être améliorer la situation.

Nous avons en ce moment vos recommandations : ce sont les recommandations de toute l'alliance, de tous les réseaux. Alors, ça représente le point de vue de la majorité des francophones à propos du service de santé.

M. Constantineau: C'est ça. C'est le point de vue de l'alliance. C'est difficile pour nous aussi parce que, pour être honnête, il y a eu une crainte que ce qu'on allait demander là était moins que ce que le comité de M. Savoie allait recommander. On avait peur un petit peu de se couper l'herbe sous les pieds en demandant moins que le comité de travail de M. Savoie avait recommandé.

Mais il y a un consensus sur les éléments là-dans. Le plus important pour nous est le préambule. Dans le préambule de la loi, on accorde aux autochtones et aux Premières nations le droit de participer au développement, à la planification et à la livraison de services de santé dans leur communauté. À tout le moins, il faut y avoir la même reconnaissance pour la communauté francophone.

Simplement dire qu'on va respecter la Loi sur les services en français n'est pas acceptable, parce que la Loi sur les services en français ne nous a pas servi jusqu'à date. On a un système « patchwork » au niveau de la province dans les services de santé en français. Ce n'est pas suffisant pour assurer une pleine participation des francophones au développement des services. Il faut aussi que, peu importe le système qui est mis en place, les francophones participent activement à la gestion de ces services de santé-là.

On a vécu, au niveau de système d'éducation, des comités consultatifs. On avait deux ou trois francophones sur notre comité de 10, 12, 14 anglophones, puis là c'est une compétition pour les dollars. La question francophone est toujours le pauvre cousin dans la déduction.

The Chair: Merci beaucoup, monsieur. We have finished our early session of the day. We will recess until 1 o'clock, after lunch. Thank you again.

The committee recessed from 1201 to 1308.

SERVICE EMPLOYEES INTERNATIONAL UNION

The Chair: We have a quorum. Even if the other parties are not present, I think we should move on so we can keep on schedule.

The next presentation is from the Service Employees International Union, Local 1, Huntsville; Susan Hughes and Janet Green. Would you please have a seat at the front, and you can start your presentation whenever you're ready. There are 15 minutes total time for your presentation. In any time left, we can ask some questions of you or make some comments.

Ms. Janet Green: Good afternoon, ladies and gentlemen, members of the standing committee on social policy. My name is Janet Green. I'm an RPN who has worked in the health care field for the past 25 years. I'm here as a representative for Huntsville District Memorial Hospital. I'm a member of SEIU Local 1 and an advocate for our community. I came here to give you an understanding of the community where I live and work—the size, the conditions etc.—but I've decided to scrap that presentation and address only the LHINs Bill 36.

What right does the government have to pass a bill as devastating as this with no public input and no public awareness? This bill ultimately affects people's lives. It affects the people who deliver the medical care, excluding doctors. Why is this? It affects the public, who need the medical treatment, and the people who give the treatment and care. It opens the door to contracting out—again, more trouble.

The Canada Health Act specifically says all residents in Canada will receive universal care. The idea of hiring or appointing people to the board in each LHIN area has me wondering why these people are not elected. Secondly, have these people any medical knowledge, since their decisions affect medical health in Ontario? We don't know, as the government has decided this is hush-hush. Bill 36 is not something to be kept quiet.

I, as a nurse, have taken an oath with the College of Nurses. I also practise a core value: Do unto others that which I would want done unto myself. I also take my job very seriously. People are putting their lives in my hands day after day.

With Bill 36, the government seems to have taken the public out of the equation. I can see that the OHIP system is faltering and changes need to be made, but at whose expense? The government talks about accountability, but for whom? The hospitals, the budgets, the government or the public?

Bill 36 needs to be looked at and studied more closely, not just rushed through and passed as law. I feel that the consumer needs to be fully aware of its global effects, as well as the medical personnel who work in the health care field. We may be able to help get OHIP back into shape.

Mr. Romanow put out many recommendations in his report to the government. His words were, "There is no quick fix." The LHINs structure is very much like the model used in the UK and Australia, which still have many problems. Good strategy does not come overnight. As part of the public, I wish to have more time to understand Bill 36 and its implications before it is passed. As well, I think the public has the right to know more.

Amendments need to be made, which include perhaps a panel of public members elected to oversee the LHIN boards. The LHIN board members should be contracted in for two-year periods. I think these positions should be elected as well.

I did up a very simple picture of a tree—I'm not an artist; I'm a nurse. The picture shows basically a very simple structure of the health care at our hospital and the system in our community. I took the roots as being the

community; the ground being the government, which nourishes the tree. The tree is broken up into different departments: the ER, X-ray, SCIU, lab, OR. If you took your finger and put it over this maple tree in any one of these sections, it's called "limbing the tree." The tree may die. Without these sections in the hospital, it does not flow properly.

With what I see in Bill 36, it basically says to me that they may contract out these positions. We have a very structured way in our hospitals, and to contract out to a company may be substandard. That is one of my worries. The lab: I've heard in the media that they've used substandard needles at some of these contracted out clinics down in the States. It bothers me.

Another area is physiotherapy. You cannot run a hospital, whether it be your ER, SCIU or OR, and not have physiotherapy for some of these people. That's another area that's being looked at. We have acute care and long-term care—again, places that need extensive physiotherapy.

Then we go up to the branches of the tree, which are some of your sort of smaller clinic areas and clinical services that are also offered. If you start limbing off a tree, if you take too many limbs, the tree is going to die. Those are extra services within the hospital. They all back up the main trunk of your tree. The maple leaves on top, to signify Canada and Ontario, are the staff and your support services that back up the main services. If you lose the limbs of the tree, you lose the staff who work in those areas.

My main concern is that when you start with Bill 36, you're opening the door for contracting out. You're opening the door for massive leaving of staff to go to private clinics to make more money, because they won't want to stay in the public system.

I don't fully understand Bill 36. I've read it over. I've read over the summary and I just feel very strongly that if I don't understand, and I'm in the medical system, and the public doesn't even know about it, there should be a longer time frame. Let the public know. Thank you very much.

The Chair: Any other comments? If there are none, there is a minute and a half. I'll start with Mr. Ramal. Less than a minute, please.

Mr. Ramal: Thank you for your presentation. You were talking about elected boards. Did you check what happened to other jurisdictions with elected boards? My second question: You were talking about not enough consultation, not many people knowing about it. Don't you think your presence today is great evidence that we are willing to consult with everyone, and that's why you're sitting before us here to tell us about your story? Is it not a consultation? Could you answer that point too?

Ms. Green: The second question first: If it were as well known in the public, I could walk up to basically anybody in my community and ask them about Bill 36, and they would have some reference to it. No one in my community that I have talked to, other than the hospital staff or medical staff in our community, knew anything

about Bill 36—nothing. I find it very odd that when it has to do with your medical treatment, you don't understand anything about a bill that's being put into legislation.

To answer your first question, I did not check out fully about the elected positions. I do know from elections provincially and federally just how crazy it can be, and I find that, yes, it might take a longer process, but on the other hand, to have someone with a medical background elected and appointed from your communities would be far more appropriate for that position in the hospital.

Mr. Ramal: But our record shows that elected boards didn't work very well. That's why we went to appointed ones, to deal with experts in that field, to appoint them in order to force the issue and fix our health care.

Ms. Green: Are these people going to be announced who will be on the boards for each LHIN?

Mr. Ramal: Of course. Some of them sat before our committee here. We listened to them, we checked their credentials and they were passed by this committee—not this committee, but a different committee.

Ms. Green: But the communities themselves? We're very tightly knit up north in Muskoka.

The Chair: Thank you. Ms. Martel, please.

Ms. Martel: It would make very good sense to have people elected from the community, because the problem with the bill is that the board members are accountable entirely to the minister, not to the community. You see that in many details in the bill: from their appointment, how long they serve, what they get paid, that they're defined as agents of the crown, that their accountability agreements are signed with the minister—the list of their attachment to the minister goes on and on. There is not a similar attachment to the community they're supposed to serve.

I wanted to focus on your concern about privatization, however, because you are quite right: The bill has more than one provision that would allow for privatization. The one I want to focus on, because you work in a hospital setting, is section 33, which essentially says that the minister can order a hospital to cease performing any prescribed non-clinical services. It doesn't have any kind of date on it, it doesn't say who they're supposed to go to and it also doesn't define non-clinical services. About some parts of your tree, we might say, "Well, that's a non-clinical service," but that's open to interpretation. Certainly, your laundry, your housekeeping, your dietary, I suspect, would be under that rubric. So what do you think about a bill that says the minister can just go ahead and order any hospital to stop performing those kinds of services, and not only stop performing, but transfer them to another entity that could be a not-for-profit or a for-profit?

Ms. Susan Hughes: At Huntsville hospital, we lost our laundry service probably about 10 years ago. Our laundry service is contracted out, and there have been nothing but problems. Every Tuesday morning, I go upstairs and look for washcloths, towels and linen of any sort, because Tuesday is delivery day. Depending on the volume of patients we may have through our department

at one given time, laundry can be down. Infection control states that we need to change pillowcases, that we need to keep our area clean, that we need to be able to wash patients, dry them etc. That's not there, so we search for it. We complain, but that is a contracted-out position. They have no control over that, and we are expected to make do.

The Chair: Thank you. Mr. Arnott.

Mr. Arnott: Thank you very much for your presentation. I apologize that I missed the first part of it. I went back to my office over the lunch hour and I had a number of phone calls. But you've got a written presentation here that I know all the committee members have, and I look forward to going through it in detail. I'm certain that my colleague Mr. Miller would want me to pass along his very best wishes to you. He's got the same problem: He has gone to a meeting and has been delayed. Thank you very much for your presentation.

1320

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0N

The Chair: The next presentation is from Julian Mazur, Service Employees International Union. Sir, you can start any time you are ready. It's a matter of 15 minutes.

Mr. Julian Mazur: I would like to introduce my colleague, Cathy Carroll, who is also from Service Employees Union, Local 1.0n.

My name is Julian Mazur. I am a SEIU Local 1.0n member. I have worked as a janitor at Toronto East General Hospital for 27 years. I have come here today before this committee to give voice to my deep concerns regarding what impact the local health integration networks will have for Ontario's health care system. LHINs will be bad for patients and health care workers alike.

I am the sole breadwinner for my family. I have an eight-year-old son to support and a mortgage to pay. I am worried that if my job is outsourced to a for-profit organization, my wages will be so low that I will not be able to support my son. I have seen hospital workers in British Columbia lose their jobs—and many, their homes—when Premier Gordon Campbell gutted their collective agreements and outsourced their jobs. Health care workers in that province now earn \$11 an hour working for companies such as Sodexo, Aramark and Compass Morrison, and all lost their pensions and benefits.

I earn \$33,500 a year. Minister Smitherman, in his opening remarks to this committee, said that 80% of the health care budget is related to human resources. This is exactly what the government wants to cut in order to achieve its balanced budget for the 2007 election. This government is going to balance its budget on the backs of those in the health care system who can least afford it. Many health care workers are immigrants and single-parent women trying to support families. Does this

government really want to create a low-wage ghetto of health care workers? Is the Wal-Martization of non-clinical services jobs going to really make a difference in balancing the provincial budget when top health care administrators in hospitals earn \$600,000 plus per year?

The real cost drivers of the health care system are doctors' fees. Last year, the Ontario government agreed to give general practitioners a 30% increase over four years. The escalating cost of drugs is also a factor.

The LHINs bureaucracy will add 550 more highly paid bureaucrats to our health care system at a cost of \$52 million on an annual basis. That's about \$95,000 per bureaucrat. Their only function will be to eliminate jobs like mine or sell them off to a for-profit company.

It will cost \$200 million to get the LHINs operational. It will cost \$20 million to dismantle the district health councils, and DHC members served for free, while all LHINs positions are paid. Twenty-one billion dollars of the \$33-billion health budget will be downloaded to LHINs. For a hospital janitor, that's a lot of money to place in the hands of unelected Liberal appointees. And I object to seeing my public health care dollars being transferred over to the private sector. Put our health care dollars to work to build a better health care system.

The new LHINs bureaucracy will not add a single new caregiver to the health care system. Does this government really want to balance the budget on the backs of the lowest-paid workers in the health care system?

I have seen what the competitive bidding process has done to my fellow union members in the home care sector. It is a travesty that these workers are subjected to poverty-level wages and do not have the same rights to their jobs, when their home care agencies are flipped, as would any other Ontario worker whose company may be sold to another. They have successor rights to their jobs, and home care workers do not. Fix this system. Do not try to foist it on any other health care workers.

In the greater Toronto area, 16 hospitals have joined together to form Hospital Business Services. All material handling at each of the 16 hospitals will be turned over to this new entity on April 1. Supervisors will no longer be hospital employees; they will be HBS employees. I believe these are just the beginning stages of the privatization of non-clinical services in hospitals. HBS is the model, I think, that all LHINs will use to move functions not related to direct patient care over to for-profit enterprises.

In Toronto there are five LHINs. Each is to develop an integrated health service plan for its specific geographical area. How then can the HBS operate as a superstructure across the GTA LHINs if the LHINs, according to Bill 36, have exclusive jurisdiction in determining what services and how services are to be delivered in their area?

Sections 26 and 28 of Bill 36 give the LHINs wide-ranging powers to privatize. The bill allows for the transfer of services from public to not-for-profit entities. Section 33 allows the Minister of Health and the government to transfer services or to have a health care provider cease performing any prescribed service. This

bill, which allows a health care program or service to be moved from one location to another, means that health care employers can apply for Public Sector Labour Relations Transition Act votes frequently. It will create labour relations chaos. The government must amend the legislation to ensure that workers' jobs will not be sold off to the lowest for-profit bidder. Health care workers must not be stripped of their union collective agreements.

As a hospital worker, I do not want to see the end of central provincial collective bargaining. Central bargaining has given stability to labour relations in the hospital sector. With the creation of the LHINs, will each LHIN become responsible for labour relations? Since a LHIN's main purpose is to cut costs, the first thing a LHIN has to do, as the minister already has, is find ways to reduce the human resources component of the budget. With the introduction of the LHINs, is there any more need for the Ontario Hospital Association to act as a lobbyist or the lead negotiator in labour relations? I repeat that health care workers must have a right to a fair and impartial system of resolving collective bargaining disputes.

The Minister of Health says that this legislation will not close hospitals, but he cannot guarantee that services will not be transferred or that some hospitals may just become walk-in clinics or be converted into long-term-care facilities.

The minister said in his opening remarks to this committee that this legislation is not going to extend the competitive bidding model to the entire public health care system. He said that the words "competitive bidding" are not in the bill. This is exactly why health care service workers are very nervous. The weasel word here is "entire." Non-clinical services will be contracted out if this legislation passes. If the government side of this committee takes the minister at his word, then I say, put it into the legislation that health care service workers' jobs will not be put on the auction block to the lowest bidder.

Why should any hospital try to save money in their budgets or create a budget surplus if the hospital has to hand back any surpluses to LHINs? Numerous times in front of a hospital audience at open forums, the president of the Toronto East General Hospital, Rob Devitt, has said how pleased he is that our hospital has a surplus in the budget or that the budget is balanced. He is concerned that the LHIN chief executive officer will take any surplus in the Toronto East General Hospital budget away for the LHIN's own use. He wonders what the point is of cutting hospital costs and carefully managing the hospital budget. Where would the incentive be to cut costs and save? How can the 14 LHINs co-operate and coordinate with each other should a plague like SARS or pandemic bird flu strike Ontario, since public health is not included in the LHINs model?

I wish to thank this committee for your time.

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The Chair: Thank you. There are about 30 seconds each. I'll start with Mr. Arnott.

Mr. Arnott: Thank you, Mr. Mazur. You've raised some very important points. We've heard from a number

of the representatives of the Service Employees International Union over the course of these days of hearings. Obviously you have good reason to be quite concerned about Bill 36, because a lot of these issues that you've raised haven't been properly addressed by the government in terms of clarification or reassurance that what you're concerned might happen will not happen. So I look to the government to bring forward the amendments in clause-by-clause that will address some of these issues, and we'll see how they respond. Thank you very much for coming in today to offer your advice.

Mr. Mazur: Thank you, sir.

The Chair: Sir, just one second.

Mr. Mazur: Sorry.

Ms. Martel: You want to run away.

I just want to focus on page 3. I'm not sure if you know this answer, Julian, or Cathy might. You referenced Hospital Business Services. What else do you know about this organization? What have you been told—I gather they're dealing with a number of unions that will be impacted by this—other than that people are going to go to this new entity on April 1? How many? Are they going to be doing their same jobs? What's the corporation's status? Is it a not-for-profit or a for-profit organization?

Ms. Cathy Carroll: Hospital Business Services is actually funded by this government.

Ms. Martel: By the ministry?

Ms. Carroll: There was money that was put in as start-up money from the Liberal government, and then hospitals were also contributing some money to it. The purpose of Hospital Business Services was to amalgamate backdoor services, as they call them: clerical, payroll, human resources.

Mr. Mazur: Stores, materials management.

Ms. Carroll: There were a number of things they started out with. Basically it's been put on hold. We have been very involved in the HBS process, and there is some collective agreement language that bars them from moving forward with their plans on some issues. But they certainly have said that they are going to start the human resources on April 1. Human resources, because it's non-union, wouldn't be covered by collective agreements, and therefore there would be an easier transition period for that time. But it certainly opens the door to the privatization of health care services, backdoor services, in the hospitals.

The Chair: Ms. Wynne.

Ms. Wynne: I'd just like to follow up on that. For Ms. Martel's information, as well, Hospital Business Services is a not-for-profit organization that's being created in order to facilitate the integration of those services for hospitals. I think it's exactly the kind of thing that we want to see happen in terms of cutting down on those administrative costs and keeping those costs in a not-for-profit system. So that answers Ms. Martel's question.

Ms. Carroll: But just—

Ms. Wynne: Can I just ask you a question on your presentation? You talked about the concern for jobs and the transition planning, that kind of thing. We have had

some of the union groups talk about the need for a human resources plan. Could you speak to that and whether you would support that idea as something we should be looking at?

Ms. Carroll: Absolutely. The government should be sitting down with the unions to develop a human resources plan. I would have hoped that that human resources plan would have been developed prior to the legislation coming into effect, that we would have had our input on the problems that would have come around the legislation as it related to the human resources issue.

You mentioned the models of BC and Alberta. In Saskatchewan there was major health care restructuring. The thing that happened in Saskatchewan was that the government went to the unions before they introduced the legislation. They consulted fully with the unions. The unions even went into the workplaces with the government to introduce the legislation and what the effects of restructuring were going to be, so that there was a harmonizing kind of air around the restructuring that the government wanted to do. We're not opposed to restructuring; it's the processes that are put into place for restructuring.

Ms. Wynne: So you would support a human resources plan being put in place?

Ms. Carroll: Absolutely. It wouldn't be in our best interests not to do that.

Ms. Wynne: Okay, thanks.

Ms. Carroll: Just to answer on the HBS, because I think it's important that you know: With the HBS, yes, it's the restructuring of it. Where the problem lies is these workers' pensions. These are hospital workers who belong to a pension plan. If they are moved into this private entity, they lose their pensions because they're no longer employees of the hospital; they're employees of the HBS.

The Chair: Thank you very much for your presentation.

CARE WATCH

The Chair: We'll go to the next presentation, from Care Watch; Bea Levis, chair. Good afternoon, ladies. Please have a seat. You have 15 minutes to make your presentation.

Ms. Bea Levis: With me is Charlotte Maher, who is the treasurer of Care Watch.

Care Watch is an incorporated, not-for-profit education advocacy organization with a particular interest in community-based long-term care. We try to help people use existing services effectively, and we advocate with the Ministry of Health and Long-Term Care and others for better access to more and improved services. We are strongly in favour of client-centred, integrated health care.

From the perspective of our particular interests, integration of services means a long-term-care continuum, which includes in-home supportive services for persons with disabilities, chronic illnesses and those with age-related disabilities.

We have been very distressed that supportive home care has all but disappeared in Ontario. This has happened without consultation or even public recognition from the Ministry of Health. We hope that the community engagement provisions in the act will be taken very seriously by the ministry so that the cynicism that many people feel after so many structural changes in health care delivery will be dissipated. We trust that everyone involved realizes that a major attitudinal shift must accompany restructuring if it is to succeed in creating positive change. It is encouraging that the committee has scheduled extra time for hearings in Toronto, and we certainly appreciate this opportunity.

Integrated health care has always sounded attractive. While the Canada Health Act, which Canadians value so highly, never contemplated anything beyond the cost of doctors and hospitals, current experience has shown that health care today has many more sectors than we have listed. Most Canadians will at some time or other need care from one, two, three or more of these sectors, often simultaneously. Integrating all sectors of our system could produce what many of us have dreamed about and talked about for years: a seamless continuum of care within which patients could move as their health needs required among various levels of care and move without delays or undue difficulties. With our currently fragmented health care system, integration means a lot of changes, and change is never easy.

In looking at Bill 36, we are looking at how its provisions would affect us and what opportunities it would provide for input from all of us, including ordinary citizens and organizations that serve and advocate on their behalf.

Our first concern is with the provision, repeated several times in different sections, that LHIN boards and organizations of health providers must make no decisions that are not in accord with the strategic plan being prepared by the Minister of Health. That plan has not, however, been made public, so that we are, in effect, being asked to comment on the means to an unknown end. Furthermore, we have had no indications that public consultation about the strategic plan is being contemplated.

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We have not forgotten that the crucial matter of defining LHIN boundaries was carried out through a method chosen by the ministry. Public input was invited only on minor adjustments to the boundaries. Yet this may have been the most critical decision in the whole transformation process.

Our next concern is with the foundation of all policy-making, which is funding. No policy can be put into effect unless adequate funding is made available. There has, so far, been no indication of the basis on which funds will be allocated to the local health integration networks. Will it depend on the population viewed through an age/gender lens? Will it be considered with a more finely differentiated lens? Will it depend on the persuasiveness of the board chairs in negotiations? Will it be adequate to enable all the services planned by the boards?

We know from experience over the years that government policy may be unarticulated but made fully effective by government funding decisions. We have pointed out that home care is a flagrant example. The previous government gave responsibility to the community care access centres to provide both post-hospital care and supportive care for the disabled, the chronically ill and persons with age-related functional deficits. The funding provided was never adequate for the access centres to carry out both functions. With patients being discharged from hospitals quicker and sicker, the available resources were absorbed more and more by the needs of discharged patients who were indeed sick enough to need in-home care urgently. Supportive in-home care has virtually disappeared, without anyone in government ever acknowledging that their policies effectively eliminated it.

Managed competition in home care is another sad example. Community-based not-for-profit agencies have been squeezed out in favour of mostly large corporations with no community ties or commitments. The essence of caring has suffered greatly. We have lost the contribution of agencies that have for many years provided excellent service and, equally important, played a substantial role in promoting caring, coherent neighbourhoods and communities.

The government must ensure that LHIN funding is adequate to meet the actual health care needs of Ontario's population.

While we welcome the inclusion in Bill 36 of a section called "Community engagement," we are not all sure when and by what means such engagement will be allowed. Open board meetings is an excellent first step. But it is qualified in the legislation by the provision that the cabinet will determine by regulation which subjects should be discussed behind closed doors. And instead of a specified number of days of public notice being required, the legislation requires boards to give the public "reasonable" notice of board and committee meetings.

We welcome also the end of cabinet appointments of board chairs and executive directors of community care access centres and their return to community control. But again, the way this will be effected is murky and obviously will take a long time. The legislation makes clear that we are not to expect any provision under the community engagement section to be actualized until a year after the legislation has been enacted.

The provision for a health professionals advisory committee seems reasonable, but it is disappointing that no provision has been made for seniors advisory committees, which the many community and health provider organizations affiliated with the Elder Health Elder Care Coalition have been urging for well over a year. The integration of care for the elderly should be an immediate and crucial undertaking for the LHIN boards, because we all know that seniors, proportionately, are the major users of health care. Priority-setting workshops across the province recognized that senior health care and care for the mentally ill should be the top priorities for service

integration. The voices of seniors need to be continuously available to every LHIN board.

Many of our members are wondering if the whole LHIN project is a backdoor way to bring in two-tier medicine. We trust this is not the government's intention, but there's not much in the legislation to reassure us. Are "the purchaser-provider split" more palatable words for managed competition? We have not forgotten how public-private partnerships were given the more palatable name of "alternate financing initiatives."

What is missing is a clear prohibition against allowing shareholding companies to invest in any sector of our health care system. Experience in various parts of the world has made it abundantly clear that when the profit motive drives decision-making in a public program, the cost goes higher and the service to the public goes lower, both in quantity and quality.

In conclusion, we hope that the government will give serious and respectful attention to the problems raised in the course of these hearings. Transforming our public health care system is a huge undertaking, affecting every Ontarian, and it will only succeed to the degree that the public as well as health care providers buy into it.

Care Watch has, therefore, concentrated our attention in this submission on two crucial questions: Will there be adequate opportunities for ongoing public input? Will there be adequate guarantees that our health care be delivered only by non-profit public health entities?

There is no question about the validity of increased service integration. We believe that such change is possible if the ministry increases its capacity to engage the community in a more forthright manner and if a collaborative rather than a competitive climate between providers is cultivated.

The Chair: Thank you very much for your presentation. There is no time for questions. I know you were ready for them, but we don't want to have the other people waiting. Thanks very much, though, for making your points.

Ms. Charlotte Maher: It was a good presentation, though.

The Chair: Yes, it was—super—and we have it in writing too.

SUDBURY MINE, MILL AND SMELTER WORKERS UNION, LOCAL 598

The Chair: The next presentation—it's a teleconference—is from the Canadian Auto Workers, Local 598. Do we have Anne Marie MacInnis on the line?

Ms. Anne Marie MacInnis: Yes, I'm here.

The Chair: Good afternoon. Would you please proceed with your presentation?

Ms. MacInnis: I certainly will. Good afternoon, ladies and gentlemen. My name's Anne Marie MacInnis, and I am an activist. I've been a long-term-care worker for 25 years, and I am a member of the Sudbury Mine, Mill and Smelter Workers Union, Local 598, Canadian Auto Workers.

I was pleased to hear from Kevin Dwyer, indicating I could make a presentation to the standing committee on social policy regarding the legislative directions proposed by the government in Bill 36, the Local Health System Integration Act, 2006. I will begin with a brief summary of how health services have been affected in my community.

Citizens in our northern community in the Sudbury Basin have been experiencing challenging times in an effort to access health services. Our community was in an emergency crisis situation. There was a limited amount of long-term-care beds to meet the needs in our geographical area. People who lived, worked, raised their families and have paid taxes had to leave our community and be placed in other regions. They were taken out of our community, away from their loved ones and placed in an unfamiliar environment. Recently, we have been allocated an additional 20 long-term-care beds as a temporary solution.

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Residents in our community received health care services delivered by three independent hospitals until the late 1990s. Those three independent locations will be combining services into one facility, Hôpital régional de Sudbury Regional Hospital. The one-site hospital construction has been stalled for years. Phase 2 of this project will now move forward. This phase will be put to tender, proposals will be received and reviewed, and a contractor will be chosen.

Non-clinical services and front-line jobs have been eliminated in the Sudbury region due to the AFP redevelopment. For many years, the Victorian Order of Nurses, with roots in our community, provided quality care to people in their homes. In the late 1990s, VON lost the home care contract through the competitive bidding process. Hundreds of workers lost their jobs and many are now working for the private companies that deliver home care services for a profit. Health care services to some of the most vulnerable people in society have been cut. Clients have told me personally that they do not voice their concerns or complaints because of fear that they will be labelled as trouble and will lose the minimum services they receive.

Long-term-care residents and workers may be some of the hardest hit in the restructuring process. The government-funded long-term-care facilities had 2.25 hours per day, per resident. That funding structure was replaced by the case-mix index and case-mix measure system, which is solely based on documentation. Residents do not receive the dignity that they deserve. Staff are over-worked and understaffed and corners are cut. These facilities are their last homes. They truly deserve more in their final stages of life.

This legislation covers all hospitals, some mental health facilities, charitable homes for the aged, community health centres and government-funded health service agencies. This bill, as written, needs significant amendments. This proposed legislation must include a democratic process for community input and control. The

public must have a system to appeal LHIN or ministry restructuring orders. LHINs must be accountable to the local community and to the elected government.

This proposed legislation must include protection for all workers who will be affected by the amalgamation of services and/or closures. Most health care workers in our province enjoy the benefits and protection of collective agreements negotiated by the unions that represent them. There must be accountability and transparency at all times in our publicly funded, publicly controlled universal health care system.

The Chair: We have about a minute each for questions, and I will start with Madame Martel.

Ms. Martel: Hi, Anne Marie. How are you today? It's Shelley. Let me ask you about competitive bidding, because you are right: The VON lost its nursing contract through the cutthroat bidding process at the CCAC after 80 years in the community. I remember that the chair of the board at the time said the reason they lost it is because they had benefits and it was too expensive to pay for their benefits. So we lost them after 80 years to a for-profit company that didn't even have an office in the community, much less staff.

Given what we saw with respect to that loss and the disruption both to clients of the CCAC who had been VON clients and to the workers themselves, what do you think is going to happen if the LHINs are allowed to acquire the rest of their services in that manner? I have had an ongoing debate with the government members, who say, "The minister said in his opening remarks that competitive bidding will not be the model that's used for the LHINs to acquire services, but there isn't anything in the legislation that prohibits them from doing so."

If it is extended, given what you already saw or what we saw in our community, what do you think will happen to other workers and other patients who get affected by that kind of purchase model?

Ms. MacInnis: I think exactly what's going to happen is what we have experienced specifically in our community. What happened was that services were cut to clients who were receiving the services. We have workers out there who used to have a not bad wage with VON. Now these workers are being paid \$8 and \$9 an hour. What's happening is that there is no morale, and it's so competitive that these poor workers are working two and three jobs to make ends meet at \$8.50 an hour. What's happening is that we're really lowering the standard of living for people.

The Chair: Thank you. Mr. Ramal.

Mr. Ramal: Thank you for your presentation. I agree with you that health care in Ontario is facing a lot of problems. That's why our government and our minister are introducing Bill 36, in order to consolidate the efforts and resources to fix health care.

I was listening to Ms. Martel and you talk about competitive bidding. We cannot include all the details in the bill, but actually, what the minister in his opening remarks was very clear and obvious about was no expansion of competitive bidding. That's what he said. That's what he's going to do in the future.

I want to ask you a question. Do you think the LHIN is a good mechanism to engage many people in Ontario instead of people coming to Toronto seeking support and help and working with the minister in Toronto? Now we're shifting it to 14 jurisdictions, and every jurisdiction will be in charge of its area and will look after the people, especially people in the north.

Ms. MacInnis: I guess my response to that question would be that there are going to be service accountability agreements that certain agencies or institutions are going to have to sign. My concern is that when it comes to procedures in hospitals—I know that the cataract procedure has often been used—what's going to happen is that the hospital that bids the lowest to perform these procedures is where people are going to have to go. I'm from the Sudbury region. In the event I needed cataract surgery and, say, Toronto won that, that would mean I would have to travel, that I would have to leave my area to go down and receive that treatment.

One of the biggest things with this is that there has to be some democracy and communities have to be involved. There has to be a process in the event that we don't agree with what's happening. We should certainly have a voice.

Mr. Ramal: Definitely. It's very clear in the bill that community involvement and input are very important to us, to our government and our minister. It's stated very clearly in the bill. I wonder if you have read the bill or not.

Ms. MacInnis: I'm sorry?

Mr. Ramal: Actually, we have said it many different times in this committee during the last seven days. Many people ask about community involvement, and we have said very clearly that community input is very obvious and very important to us in order to proceed with our services.

Ms. MacInnis: Absolutely.

The Chair: Mr. Arnott, please.

Mr. Arnott: Thank you very much for your presentation. You've made a lot of very interesting points. You've highlighted some of the concerns I've had about this bill, having gone through a number of days of public hearings now. Really, there needs to be an independent and impartial appeal mechanism for communities that disagree with a LHIN decision. Somehow the legislation has to be amended to allow for that, so that there's a fair and independent appeal mechanism. I assume you would agree with that and would support an amendment of that—

Ms. MacInnis: Yes, I would.

Mr. Arnott: Okay. There is another big concern I have. You mentioned the issue of democracy and so forth. Bill 36, of course, is not the law of Ontario. It hasn't passed through the Legislature. However, notwithstanding that fact, the government moved ahead without the authority of the Legislature, without any legal basis, to set up the LHINs, hiring 14 executive directors and installing a number of board members. Do you not think that is, to some degree, contemptuous of the legislative process and contemptuous of the Legislature?

Ms. MacInnis: Hello?

Mr. Arnott: Can you hear me?

Ms. MacInnis: Yes. I can now. I'm in the car. I'm travelling. Was there a question?

Mr. Arnott: Would you agree that the legislative process has been usurped and the government has demonstrated, to some degree, contempt of the Legislature by moving ahead with establishing the LHINs without the legislative authority to do so?

Ms. MacInnis: Once again, I totally believe in the democratic process. I believe there should have been input from citizens, from the public and from the communities, and certainly recommendations. I believe there should have been some input.

The Chair: Thanks very much for your presentation.

Just for the record, I have been reminded that the Speaker of the House ruled in May 2005 that what the minister did was acceptable.

1400

CANADIAN AUTO WORKERS, NATIONAL OFFICE

The Chair: The next presentation is from the Canadian Auto Workers, national office. We have a team. Good afternoon.

Mr. Corey Vermey: Good afternoon. Unfortunately, Paul Forder, our director of government relations, was unable to attend. He's recovering from the announcement of the federal cabinet earlier this week, and we're trusting the health care system in Ontario will stand him in good stead.

With us today on behalf of the CAW national office is Darlene Prouse, the Ontario health care council president and a vice-president of CAW Local 2458; Nancy McMurphy, who sits on the CAW national executive board and is president of Local 302; and Barb Maki, who is with CAW Local 229 from Thunder Bay and sits as vice-president of that local as well.

We thank you for the opportunity to present some very brief remarks. We have a fuller submission, to which we hope those who want to engage in the issues we raise will refer in terms of the supporting rationale. Obviously, we wouldn't have the opportunity to engage fully in this debate within the 15 minutes allotted by the clerk to our presentation today.

We certainly welcome this opportunity and want to preface our remarks by clearly supporting the effort toward integration and indeed the broader transformation of the health care system. It's one that our union and I think all advocates for medicare and a publicly funded and delivered health care system can endorse. The issue, however, with the legislation as proposed does give us several concerns. We see inadequacies in several fundamental areas, sufficient that without significant amendment to the bill, and we understand there are substantive amendments that have been brought forward to the attention of the standing committee, our union, CAW Canada, cannot support this legislation short of those

issues being addressed, and we trust the committee will so advise the Legislature in its report.

The two key areas of fundamental concern for us are the absence of any meaningful public consultation or civic engagement. We have read the proposed legislation and are aware that there are references to obligations to engage in civic engagement. We believe that the statute, if passed by the Legislature, should set out very clearly and substantively what those obligations are and what the respective parties bearing those obligations will engage in in terms of ensuring a democratic and equitable representation of the diversity within our province and our communities.

We had hoped that this juncture in health reform and transformation would have been a jumping-off point for permitting communities and the people of Ontario to more actively participate in the policy dialogue and the policy choices and debate surrounding health care delivery, and they are clearly significant issues for the people of Ontario.

Secondly, as the largest private sector union in this province, we also represent some 20,000 health care sector workers. We would wish for no less for those 20,000 health care workers than we work for on behalf of our private sector membership, and that is that there be a labour adjustment strategy in the first order, a provincial sectoral strategy, in which the effect upon health care workers is addressed, and in specific instances, in terms of transformation, integration or coordination by the LHINs, there are human resource plans negotiated to address those effects.

One considerable concern we have in the legislation is the distinction that is drawn between professional and, therefore, non-professional, and between clinical and non-clinical. Quite recently, we had a hospital approach us as the bargaining agent and advise that they were taking a classification, "patient service associate," a generic, multi-skilled classification that they had employed for over 10 years—it was essentially a patient-centred, patient-focused single point of service within a hospital setting—and preparing to disentangle the various functions and return to the dietary, housekeeping and nurse's aide roles that had existed in the past. It was very clear that that initiative flowed from their reading and understanding of Bill 36 and the distinction in that proposed act around "non-clinical." To us, that certainly does not seem to be an effective care model to be pursuing.

We certainly will continue to engage the government and our communities on the proposed legislation and the ongoing efforts around transformation. We are trusting that it will be understood that the CAW will not accept any rollback or lessening of the current standards with regard to the fundamental areas of concern for us; namely, the democratic input and engagement of citizens. We would expect no less than what would be current in terms of involvement and disclosure with public hospital boards, for instance, nor anything less in terms of the participation within our communities and recognition of rights of health care workers.

I turn it over to Nancy at this point.

Ms. Nancy McMurphy: We recommend that the proposed application of Bill 136, Public Sector Labour Relations Transition Act, 1997, under section 32, extend to any integration under the act without exception, including when the successor employer is not a health service provider or its primary function is not the provision of services within or to the health services sector.

We further recommend that the proposed section 33 of the bill, permitting by regulation an order that a public hospital cease performing any prescribed non-clinical service and transfer such services to another entity, be removed from the act, or alternatively, that subsection 33(3) be amended to clearly provide for the application of Bill 136 to any order, direction or decision affecting non-clinical services performed at a hospital or other health service provider.

We insist that the transformation or integration contemplated under this proposed act not proceed without a negotiated provincial labour adjustment framework and LHIN-based human resources plans or programs to deal with the potential adverse impact on workers that may arise.

We would recommend that the bill be amended to require the minister, prior to issuing the provincial strategic plan, and the LHIN, prior to the release of an integrated health services plan, both develop a human resources plan through negotiation with affected employee representatives that sets out the labour adjustment obligations necessary to minimize any potential adverse effects of integration strategies or health service workers.

Ms. Darlene Prouse: Legislative purpose: We recommend that matters set out in the preamble be included in the purpose of the act, reflecting the earlier legislative intent adopted in Bill 8, and particularly to affirm that a strong health system depends on collaboration between citizens and their communities, health service employees and employers, and government.

We would also like to recommend that the proposed purpose of the act at section 1 include "improving patient safety; enhancing workplace health and safety and improving quality of service and outcome," to provide greater balance to the current wording, "effective and efficient management," by focusing on both.

Civic engagement: We recommend that the references in the preamble to enabling local communities to make decisions about their local health systems be expressly added in the purpose clause and strengthened with express obligations for equitable representation of the diversity within our communities in the development of the provincial strategic plan and of local communities in the development of integrated health service plans.

We would also like to recommend that the bill be amended at subsection 16(2), which requires the LHIN to establish a health professionals advisory committee, to also require separate advisory committees for representatives of the various communities and for non-professional employee representatives from the health services provider within the LHIN, including represent-

atives from the major health bargaining agents and labour council bodies.

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We would also like to recommend that, at a minimum, the LHIN board be subject to:

- the same obligations as in Bill 123, requiring openness and access for the public to meetings of provincial and municipal boards, commissions and other public bodies; and

- conflict-of-interest guidelines, as previously applied to the district health councils and other non-profit voluntary boards in the health sector, must apply; and

- appointments be restricted to Ontarians who have demonstrated in their public life to the people of this province or their local communities a clear, non-partisan commitment to the principles of medicare.

Ms. Barb Maki: In conclusion, we commend the government for its ongoing commitment to securing the future of medicare in Ontario through adoption of many of the recommendations of the Romanow Commission. As the Minister of Health stated to the Legislature on November 27, 2003, in presenting Bill 8, the Romanow report came to one pivotal and irrefutable conclusion: the pursuit of corporate profit weakens, not strengthens, health care. The test of both Bill 8 and Bill 36 in recognizing the legacy of the deep and profound commitment of Canadians to medicare is whether such legislation strengthens and deepens the ability of the people of Ontario to hold their provincial government, LHIN board and local health care providers accountable for strengthening health care. As well, there must be a strong resolve to resist creeping privatization that threatens access, quality and sustainability of universal public health care.

The Chair: Thank you. There's about three minutes. Mr. Fonseca, one minute, please.

Mr. Fonseca: I'd like to thank the CAW for your presentation. I know many of your comments were made around community engagement and, really, that was at the heart of this piece of legislation as it was being put together. The minister wanted to make sure that the definition of "community" was one that would be broad yet inclusive, so that it would involve patients, individuals and health care workers, and did not want it to be constrained in any way in terms of how that engagement would work. From the beginning, he's had much consultation with the community. Some 4,000 to 6,000 people have come forward at different town hall meetings. We're going through this process right now in committee. But moving forward, I think what the minister is envisioning and what communities want are town halls and any way that they can put their voice forward and engage in this process. How would you see it happening in terms of community engagement? What would be some of the best vehicles towards having that dialogue?

Mr. Vermey: Our first proposal would be that the model of governance in the school board and municipal sector be relied upon. The LHINs will be entities with substantial resources, covering a much larger jurisdiction than existing school boards or municipalities. But clearly,

we have a long tradition in Ontario of electing at those levels representatives from our communities to engage in the governance of those systems. We're somewhat disappointed that that hasn't been part of the discussion the minister has had with the province.

We understand that those long and deep traditions cannot be created overnight. We understand that there may be a need to evolve towards a situation where the people of Ontario are ready to govern their regional health structures in such fashion.

Mr. Fonseca: One of the things about that is that in Ontario, because we were the last to bring in a form of regionalization, we were able to learn from many of the other jurisdictions, which did bring forward elected types of boards, and they've all reverted to appointed because they found that it didn't work. What we've done is learn from their mistakes and bring forward the best, so that these appointees can have the knowledge and skills that are needed to be able to address large concerns and issues around health care. We want to make sure that people have the right skills to make those educated decisions for the community.

The Chair: Thank you. Mr. Miller.

Mr. Miller: Thank you for your presentation. You said at the beginning of your presentation that you support integration but you wouldn't be able to support this bill until you at least see the amendments that will be coming forward. On that point, Mr. Chair, a question for you that was also asked of me by the Grand Council Chief of the Anishinabek First Nation, John Beaucage, that the committee be able to see the amendments, particularly as they relate to First Nations, as soon as possible. I'm wondering when the government might have the amendments to do with First Nations and when the opposition will be able to see those amendments.

The Chair: When the whip has a seat, I will ask her to potentially answer your question, if she has an answer.

Ms. Wynne, there's a question for you, if you can answer. Mr. Miller would like to know if the amendments that the minister is—

Mr. Miller: Particularly as they relate to First Nations, when we might be able to see them, when they'll be ready, to be sure that we're going to have enough time to—

Ms. Wynne: My understanding is that the committee will receive the amendments at the same time as all the amendments come forward, but the minister is in an ongoing conversation. There will be another conversation with the First Nations folks. So they, I hope, will see the amendments before we do. I think that would be appropriate.

The Chair: Okay, thank you. Ms. Martel.

Ms. Martel: Thank you for your presentation today. A comment and then—maybe two comments. Let me see if I get a question out of this.

The first one has to do with the absence of any meaningful public consultation or civic engagement. The bill is so bad that when a LHIN makes an integration decision, the only group that has to be advised of that is the health services provider. There's not even a mechanism

here for the community that's going to be affected to have a say. Where's the meaningful consultation and dialogue when that kind of decision-making can go on? Over and above that, the service provider has 30 days to respond, and he or she responds back to the same group that made the negative decision in the first place. So it's hard to imagine much of a positive change happening from that process.

Secondly, I'm glad that you made the point about the provider, who for 10 years has had this patient service associate position and is now advising you, as the bargaining agent, that they want to change the makeup of that position. There's been quite a debate in this committee around section 33 and whether or not it opens up for privatization. I have consistently argued that yes, it does. It's one of several sections in the bill that does. It does from the fact that it is completely limitless in terms of when any of these orders can be made by the minister for a hospital to cease and desist from providing a service. Over and above that, "non-clinical" is not even defined, so that leads us to significant interpretation from one side or the other about what non-clinical is.

Given that you've already brought to the committee's attention today a very real scenario that flows from this section, how concerned are you, if we don't repeal that, that you're not going to see more of the same, not only with you as bargaining agents representing workers, but other unions representing other workers facing a similar thing in their own hospitals?

Mr. Vermey: Very concerned. Obviously, in this situation that we've brought to the attention of the standing committee, it's a very large tertiary hospital in one of our large urban centres in the province. Because it is a multi-site hospital, on one of the sites there is a for-profit multinational cleaning contractor.

It's very clear that as long as there is fiscal pressure on that hospital, there will always be a sort of knee-jerk reaction. One of our concerns is that the past history of restructuring in Ontario has always focused on the labour side as the easy area of savings. As opposed to looking at clinical utilization, looking at harnessing our medical and nursing protocols of care or diagnostic testing and really making sure we're efficient in those respects, we immediately look for very quick-fix solutions around how housekeeping or dietary services are provided. That's an indictment of health care service providers as much as it is of any policy of a government, present or previous. However, the issue is, this clearly has been a signal received by the health care providers, and we're very concerned about that very specific aspect of this legislation.

The Chair: Thanks very much for your presentation.

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NATIONAL PENSIONERS AND SENIOR CITIZENS FEDERATION

The Chair: The next presentation is from the National Pensioners and Senior Citizens Federation; Art Field,

president. Mr. Field, if you can have a seat, there are 15 minutes for your presentation and potential questions. You can start any time you're ready.

Mr. Art Field: Thank you. I don't have a brochure to hand out like everybody else. I have 10 points to bring up, and we'll go from there.

I'll explain our organization first. I'm Art Field. I'm the president. The National Pensioners and Senior Citizens Federation was incorporated in 1954 in Saskatchewan. We're a federal organization. It's not by design, but our first vice-president is from British Columbia; our secretary is from Saskatchewan; I'm the president, and I live in Ontario; the treasurer lives in Ontario; our third vice is from Windsor, Ontario; our second vice is from Nova Scotia; and up to our last convention we had a third vice, who was a past president, from Newfoundland. Our main objective is that we go to Ottawa and meet with the government and the opposition MPs with briefs from our convention.

I live outside Lindsay, Ontario. There's a high density of seniors. That's one of the reasons I'm here. I've been very involved in my community in all sorts of activities, so I have an idea of what is going on.

I am concerned. Central East: city of Kawartha Lakes, Northumberland, county of Haliburton, Durham region, Scarborough and Peterborough. I don't know what Scarborough would have in conjunction with Lindsay or even Peterborough. I think it's too big an area. We've gone through this with the school boards. I don't know if it's working or not, but they do have elections.

As I said, we have a high population of seniors. Lindsay hospital has an elected board. I go to the board meetings when they have elections. I've never been on the board. Lindsay hospital has 400 volunteers in its auxiliary. I don't know how that hospital would run if it didn't have the 400 volunteers. It also has an excellent emergency service. I am told by the people in the hospital that it is probably the most used emergency service in Ontario because people come in from Oshawa or whatever. I know, in my trips there, I always count the people in there. There are lots of people, but they're getting the service.

The other thing is, I don't think we need any more contracting out. I understand, through my vice-president in British Columbia, that BC has sort of the same system and they're not too happy with it. One of the appointments to their board or LHIN, as you call it here—I don't know what they call it out there—was the CEO from London Drugs. I don't know if he has a conflict of interest or not, but it would be scary. I think that this will lead to more privatization of health care systems, and it's creeping into Ontario now. Our association is definitely against that, and we've had a lot of resolutions at our convention on that.

Point number eight is the lack of democracy and the lack of access to information.

Number nine: A community loses input—I picked up a couple of things here listening to the presentation ahead of me. Seniors aren't a minority group anymore. We're a

majority, but sometimes we've been treated like a minority. I realize it has nothing to do with here, but the new federal government—that I saw, anyway—didn't appoint anybody to the seniors portfolio.

Those are just some short things that I have brought from our travels around. As I say, I didn't have anything put together. We are a volunteer organization and we don't have an executive director. We went through that scenario and went broke. So now we're on the other scenario of getting it back together. I just hope that I put some input to help things here. I will answer any questions, if capable.

The Chair: There is time. There is about a minute and a half for each group to ask and for you to reply. I will start with Mr. Miller.

Mr. Miller: Thank you very much for your presentation. It sounds like you're very involved with the community. You highlighted all the good work the 400 volunteers do at the Lindsay hospital, and certainly I'm sure they're valuable, as they are at all hospitals across the province.

One of the points you made was that the LHIN for Lindsay also includes Scarborough. It's large, for one thing, and the boundaries aren't necessarily where you think they are. The government has split the province up into 14 local health integration networks. Have you got any recommendations on how, if you're going to go to this regional strategy that they're heading towards, you would split the province up other than that? They claim it's based on referral patterns.

Mr. Field: We're still rural Ontario, and you're putting Peterborough in with us, which has a fairly large population, as you know, and then Scarborough and even Durham region. I worked in Oshawa for 35 years; I was a CAW member, so I was listening to the presentation before. There's a difference. We always had the little joke that once you get over the ridges, the thinking is different. The thinking is different in politics and all the other things that go on. I don't see why our health system has to be tied, in even with Durham region, to be truthful, even though General Motors is the largest employer in the Peterborough, Lindsay and Halliburton area. Still, I think to keep ourselves under—that way, we don't need those big centres. Will they be the big ones and control it? I don't know. I just think it's wrong because you're getting different people with different thoughts and a different lifestyle.

As I say, we have the 400 volunteers. I don't know how other hospitals work. I know there are some problems in the Oshawa one, because we, the CAW, used to donate a lot of money to them through payroll deductions and everything, or the union would give, and I think we had a member on the board. I know there are problems there, but the Lindsay one seems to be going very well. Of course, there's a lot of usage there, but I've seen that it's well run. All my children were born there, and my wife just came out of the hospital last week after a woman's operation. So my agenda, even though I'm in a national organization, is that I just want to keep us with

our situation. I have nothing against the Durham region or Oshawa or Scarborough, but there are different thoughts there.

The Chair: Thank you. Ms. Martel, please.

Ms. Martel: Thank you for being here today. You know that I'm from Sudbury, and we used to say, "The thinking is different when you get past Wonderland."

Mr. Field: Well, you've come a long way.

Ms. Martel: If you go to northwestern Ontario, it's when you get past Sudbury that the thinking is different too, but we won't talk about that.

From my part of the world, the North East LHIN goes from James Bay down to past Parry Sound and points in between—34 hospitals—with a major regional centre in Sudbury and some bigger centres, clearly, in some of the more major centres of Sault Ste. Marie, Timmins and North Bay. Folks at home are worried about this: They look at this bill, see the words "integration" and "consolidation of services," and say that the real aim here is going to be for the minister, through the LHIN, to figure out how we can centralize a lot of hospital services either in Timmins, North Bay or Sault Ste. Marie, or then further centralization into Sudbury, because it is already designated as a regional centre. Those concerns are legitimate, because we know people travel now to Sudbury for cancer, for neonatal services, for cardiac. Sudbury might benefit by having even more people travel, but I don't want to see that. I want to see people get their services close to home.

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When you look at your LHIN and the composition, which is rural, suburban and then very metropolitan, are the folks saying those kinds of things to you too? Is their concern that by the time this is all over, community hospitals at which you used to receive services, which they have supported through their tax dollars and perhaps through the municipality and through fundraising, are going to be hospitals that no longer have those services, and they're going to be travelling long distances to a major medical centre to obtain what they could have got close to home before?

Mr. Field: Yes, that's what we're concerned about. But the other thing is, some of us who are active in the community understand what's going on. I like to say we want to keep it rural, but we also are a bedroom community to Toronto, Oshawa and whatever, because they do travel, and some people don't take part in it. I just think the LHIN with Peterborough, Durham and Scarborough is wrong. I understand what you're saying; you've got a lot more land or more people—not people, more area—

Ms. Martel: More land.

Mr. Field: Our area is growing. They're building houses all over the place. But I just think it's wrong. Maybe you appoint somebody from Lindsay and another person is from Scarborough or whatever, and the thinking is different. There's nothing wrong with it, but I think we should be all on the same page here.

The Chair: Ms. Wynne.

Ms. Wynne: Thanks, Mr. Field, for being here. A couple of things: Right now, as it stands, the planning is done centrally in Toronto. There isn't a LHIN board that you can contact or that you can go to a meeting of, where you can hear what the local planning is. There really isn't anywhere you can go to get a sense of what the gaps in service are or what the future plans are for service in your area. You'd have to come to the ministry. You'd have to talk to people at Queen's Park.

We're trying to set up a structure that will allow you to have a place that you can contact. You'll have a group of people who are dealing with the service gaps in your area, albeit a broad area, and you will then be able to contact those folks and you'll know what the service plan is for your community.

I think the reason that the LHINs are shaped the way they are—and you mentioned it, or one of the opposition members mentioned it—is because of referral patterns. When people need a particular service that's maybe a once-in-a-lifetime service, they go to the larger centres. But there's nothing in this bill that suggests that all the services would be sucked out of the Lindsay-Peterborough area and put in Scarborough. That's not the idea. The idea is that when people need a service, they can get that service in a reasonable amount of time.

That's why we're putting the local health integration networks in place; in fact, the opposite of what you're saying or being told, that the community will lose input. We're trying to set up a situation where there will be a board of people who will actually be connected to you. I just wanted you to comment on the part of the bill that says the local health integration network must have a community engagement strategy, they must engage the community. And that means all the communities in their local area. They must engage those communities in a dialogue about the plan. Is that, to your mind, a good thing?

Mr. Field: In my mind, I think if you've got to make the change, there are not enough LHINs. You've got 14, you've got a billion-dollar budget and Ontario is the highest-populated province in the country. There are not enough of them. Your diverse thinking or lifestyle is different, and you're sort of putting us all in this one pot here. It doesn't work, and people don't take part in it.

Ms. Wynne: The Chair is going to cut me off, but just so you know, there is a mechanism whereby more LHINs can be created if, in the future, that's deemed to be necessary. Thank you for your input.

Mr. Field: That would be tough. Once it's in, you generally don't want to add them.

The Chair: Thank you very much for your presentation.

ST. CHRISTOPHER HOUSE

The Chair: The next one is from St. Christopher House; Susan Pigott and Odete Nascimento. Good afternoon.

Ms. Susan Pigott: Good afternoon.

The Chair: You can start any time you're ready.

Ms. Pigott: All right. Thank you, Mr. Chair. Good afternoon, committee members. My name is Susan Pigott, and I'm the chief executive officer at St. Christopher House. With me today is the director of our older adult centre, Odete Nascimento.

I'm going to make a presentation and, when there are questions, I think both of us will take the questions.

Before I begin the formal part of our submission, let me point out that one of the other things I have the privilege to be involved in is as a board member of the Hospital for Sick Children here in Toronto. I have been on that board for the past seven years, and that experience has given me some sense of the pressures that are on institutionally based parts of the health care system, particularly the pediatric health care system, and has led me to understand how important it is that we have a good continuum of care that makes full use of the capacity of the community-based sector, if we're to make intelligent economic decisions around health care. That doesn't mean off-loading of services from the hospital sector on to the so-called cheaper community-based sector, but it does mean careful planning and adequate resourcing of this kind of transition.

Having said that, let me get into the submission, and you'll see we come back to these themes throughout. Very briefly, by way of introduction, we have provided written submissions, so I'm going to trip over this pretty quickly.

St. Christopher House is a community-based, multi-service agency in the downtown west end of Toronto. We've been providing services to the people in our community since 1912. We provide a wide range of services to people from all different cultures and all different ages. A significant amount of our work is done with elderly and disabled people, and also people with mental health problems.

Our services that would be of particular interest to you would include client intervention and assistance, Meals on Wheels, home help, respite and homemaking, transportation, friendly visiting, an Alzheimer day program, a frail elderly program, and caregiver counselling and training. In addition, we have an elderly person centre where we do socialization, fitness, wellness and health promotion activities. We provide our programs in four main languages: English, Cantonese, Portuguese and Vietnamese. These languages correspond to the primary language groups in our neighbourhoods of our downtown west end. We also run the Meeting Place, a drop-in for homeless individuals at Queen and Bathurst. Many of the people in this program unfortunately have drug addiction and mental health problems.

That's a little bit of a sense of who we are, and we're very pleased to have this opportunity to provide some input to your deliberations. We share the aspirations of the LHINs to better integrate health services and to develop a seamless continuum of service that is easily accessible to clients, and a system that makes efficient and effective use of health care dollars.

One of the things I want to spend a bit of time on now is what we've called in our paper "Understanding the role of community-based agencies in the LHIN." We are aware from previous deputations and from ongoing discussions we've had around health care issues that our sector is poorly understood. People want to know, why are there so many agencies like yours? Isn't there a better, more efficient way of organizing? I want to try and get beneath some of those questions and provide you with a bit of a sense of why we think we're so vital.

We are one of hundreds of locally based community agencies which, taken together, form a strong web of support for many of the most vulnerable people in our communities. We think that understanding how we work and the role we play in the system will be very important to the overall success of the LHINs.

First of all, we are the health care providers who help people to live independently in their communities, and in so doing, to prevent unnecessary hospitalization. We are also the providers who allow people to leave expensive hospital settings, because we support them in the community. We think the maintenance and ongoing development of the community-based sector is critical to the success of the LHINs.

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In addition to providing some of the hard services I've outlined, we also fulfill the following functions.

We're the eyes and ears on the community. We can inform the LHINs on an ongoing basis about emerging community needs, either new populations or new health problems.

We have a long history of collaboration. You are hoping in the LHINs legislation to encourage collaboration. You would have been hard put to find better examples of collaboration than what exists presently among the community-based sector. We're very experienced at working in partnership.

For example, in Toronto, community-based agencies, a network of 11 agencies, for many years now have worked together to provide transportation for seniors. We've managed to accomplish on our own a very effective transportation system for seniors. We have long-standing partnerships, many of us with hospitals. In our case, our older adults' centre has worked very closely with the seniors' wellness clinic at the Toronto Western part of the University Health Network for many years. What we've managed to do is provide the ability for the hospital to reach people in many different languages and across culture lines.

To give another example, the West End Urban Health Alliance is a long-standing network of community-based, hospital health centre organizations in downtown west Toronto that very effectively, again on our own initiative, have been working to try to improve the continuum of care in our community.

We are the conduits for health promotion information. Agencies like St. Chris, in our case through our innovative Health Action Theatre by Seniors—many of you may be aware of HATS—are able to reach out and do

health promotion in many languages and to many different cultural groups.

We work well with our clients and participants in our programs to address the broader determinants of health: poverty; inferior housing; we work with people who are lonely and isolated; we also bring together segments of the community to address some of the bigger systemic issues.

We are an integral part of crisis response because we are nimble, close to the ground and can mobilize volunteers in our communities. We've seen two examples of this recently. One was with SARS, and the other was the blackout in Toronto, where, I have to say, in our part of town, our Meals on Wheels volunteers were the people who actually were on the ground with so many seniors who were in apartment buildings, terrified in their rooms with their door shut and no lights. The people who were there and able to get to them were our Meals on Wheels volunteers. We even had a volunteer who climbed 32 floors to get to the top of a building during the blackout because there was no elevator. This is not something to overlook in a time of crisis.

Finally, we harness the power of thousands of volunteers and other resources beyond the Ministry of Health. We bring those to the LHIN system.

These are the attributes of our community-based sector, and we are very concerned that Bill 36 and the implementation of the LHINs process does not undermine our capacity to fulfill these functions.

For that reason, we want to emphasize a couple of the recommendations—

Interjection.

Ms Pigott: Two minutes? I'll touch on them very briefly. You've heard about most of these from the Ontario Community Support Association.

We are very concerned that the local health advisory committees have inclusive representation from organizations that are in the community-based sector. We can only be an effective part of the LHINs planning if we're at the table, up front, making the plans along with the other players. It will not work if the plans are made and then dumped on us and we're expected to mop up or to pick up the pieces of decisions that are made that are not likely to be well executed in the communities.

We're very concerned about issues related to community engagement that we've heard about before. We are particularly concerned about language issues in a city like Toronto and in communities like ours, where there are very many people who are not going to be easily engaged unless we're attentive to their language needs.

I would just say, finally, that we're very much feeling that the role of the CCACs should be confined to the health care services they currently broker. We are not big fans of managed competition. We believe in accountability. We believe in quality of services. But we believe, more than anything, in ease of access and continuity of care for people who need our kinds of services.

I've really cut short the recommendations, but they're not ones that you haven't heard before. They're in our submission.

In closing, let me just say how much we look forward to playing a role in the implementation of the LHINs, but in order to do that we have to be at the table and we have to be part of the planning of health care services in our communities.

The Chair: I want to give 30 seconds each to ask questions.

Ms. Martel: Actually, I just want to make a point. Thank you very much for reinforcing the attributes of the community-based sector.

I'm a cynic. Maybe I've been here too long, but I look at this and think that this legislation is a mechanism for the government to essentially reduce the number of not-for-profit community agencies out there, saying that there's too much duplication, whether it's in the mental health sector or the community support sector etc.

What I know from my communities is that those organizations have had long-standing relationships, for many years now. They didn't have to be told to get rid of duplication and to work together. They've had to by necessity; in our part of the world, sometimes by necessity of geography. But certainly they have been working together for many, many years now. The issue among them is not finding savings by getting rid of it. What they really need is some more money to provide the very good services that they're trying to deliver.

I just want to say thank you for reinforcing why so many of these not-for-profit providers have a particular place in the whole continuum of care, one that we should respect and not be looking to get rid of in the name of duplication or whatever name you want to attach to it.

Ms. Pigott: Thanks.

The Chair: Mr. Fonseca.

Mr. Fonseca: Susan and Odete, thank you very much. As you know, my grandmother is one of the members at St. Christopher House.

Ms. Pigott: We do know that.

Mr. Fonseca: Following up on some of the remarks that Ms. Martel made, we want to use a situation like yours, where it's community-based. I've seen the excellence that you provide in terms of care and service, and how you've worked to collaborate and integrate with all other community providers and our hospitals etc. What we're trying to do with the LHIN—do you feel this is a good process?—is to take your model and transplant it all over the province. It's not happening everywhere, but we want to make sure that those best practices do happen in other communities so that people could get the great care that I know my grandmother does at St. Christopher House.

The minister has toured your facility at Dundas and Ossington. He's well aware of the great work you do, and he has said that this is what he wants to see in communities across Ontario.

Ms. Pigott: Thank you very much for that. Of course, I'm not going to say that we wouldn't like to see that happen everywhere, but I just want to make the point that there are certain conditions in our environment for doing business that allow us to be able to do what we do: We

have some long-term stability in terms of being able to plan and to attract and maintain excellent staff and volunteers, to be able to locate our services for seniors alongside services for other populations so it doesn't become a sort of ghettoized situation, and the ability to not try to do everything but to concentrate on what we're good at and work in partnership with other organizations.

These very factors that help us be as good as we try to be are things that we are fighting to protect in this current health funding environment. We just want to make sure that the LHIN process does not inadvertently undermine the very conditions that allow us to provide relatively inexpensive, high-quality care in our communities.

The Chair: Thank you. Mr. Arnott, please.

Mr. Arnott: On behalf of the Progressive Conservative Party of Ontario, I want to express my appreciation as well to your organization for the good work that you do.

I don't have a lot of time, but I just wanted to ask you about community engagement. What would you like to see in terms of a response by the government to ensure that good community engagement takes place at each and every LHIN across the province?

Ms. Pigott: I think what would be very helpful is if we could actually see in the LHIN legislation itself a little bit more language about community engagement that at least refers to the fact that we live in a multi-lingual, multicultural society, and that there are extra efforts that have to be made, particularly where there are large non-English-speaking populations.

Then in the fine tuning, I think it would be very important to try and have each LHIN determine what is the appropriate level for community engagement in that particular LHIN. Community engagement is one of these terms that really can be a once-over-lightly kind of thing, and we want to see that it's meaningful and deep.

In terms of actual changes to the legislation, what we would like to see addressed at the very least is the language issue. It seems hard to believe that it wouldn't be in a province like this in this age.

The Chair: Thank you very much for your presentation.

Ms. Pigott: Thank you for all your hard work. Good luck.

1450

TORONTO HEALTH COALITION

The Chair: The next presentation is from the Toronto Health Coalition. Good afternoon, ladies. You can start any time you're ready. There are 15 minutes in total.

Ms. Pat Futterer: I am Pat Futterer of the Toronto Health Coalition. My colleague on my left is Christine Mounstevan, and Gerda Kaegi is on my right.

The Chair: Welcome.

Ms. Futterer: Thank you. The Toronto Health Coalition, a non-partisan organization founded in 1998, is one of over 50 local health coalitions in communities across the province. Although our members come from

all walks of life, all political parties and diverse cultures, we have a common goal: to maintain and enhance a quality, universal public health care system under the principles of the Canada Health Act. We are closely affiliated with the Ontario and the Canadian Health Coalition.

The first duty of any government is to protect its citizens. Public trust is at least partly predicated by taxpayers' faith that their government is advocating on their behalf, getting the best deal possible and, in this case, ensuring that we all have universal access to quality health care.

Certainly the aim as presented in the preamble to the Bill 36 legislation regarding the integration of health care in Ontario would suggest that the government is indeed advocating on behalf of all of us in Ontario. No one could possibly object to a commitment to equity and respect for diversity, better co-ordination of health service delivery to make it easier for people to access health care, public accountability and transparency, and so on.

In the *Toronto Star* on February 5, 2006, our Minister of Health and Long-Term Care was quoted as saying that critics of Bill 36 are "wedded to the status quo." Not so. It would be very naive on our part to pretend that we have a perfect health care system; we don't. We know that our system is ailing. It needs to be revitalized, and so the promise of an "integrated health system" that will "improve the health of Ontarians through better access to health services" as outlined in Bill 36, is very seductive. However, we are members of a watchdog organization committed to the preservation of public, not-for-profit health care, and although we applaud the intent of Bill 36 as outlined in the preamble, we have some serious reservations about what is revealed and what is not revealed in the remainder of the legislation.

Ms. Christine Mounsteven: Since the purpose of the legislation is "to provide for an integrated health system," why does it not include family doctors, dentists, optometrists and so on? How can a truly integrated system be achieved without the involvement of some of the major providers of primary health care?

Since community participation is a priority, why are the LHINs made up of boards of directors—appointed by the government, not elected by communities—whose qualifications lean primarily towards business and administration? Where are the health care consumers and service providers from the non-profit system? According to the information on the government website, however, you have not completed your hiring process. We hope you will aim for a more equitable balance of board members.

My colleague has already mentioned our commitment to a public health care system under the Canada Health Act. When we attended a LHINs workshop in November 2004, Gail Paech, lead for system integration, assured us that the principles of the Canada Health Act would be upheld by the LHINs. We have noted, however, that nowhere in Bill 36 is there any reference to the Canada Health Act, which is, after all, the centrepiece of

medicare. Was this just an oversight? We hope that in your revision of the legislation you will make a clear commitment to the principles of the Canada Health Act.

As members of the Toronto Health Coalition, however, we are particularly concerned about the erosion of our universal health care through creeping privatization. I'm sure this isn't the first time you've heard about the threat of privatization during these hearings. In the remaining few minutes of our presentation, we will focus on what we fear may be an ever-deepening threat of privatization in our health care system as revealed both explicitly and implicitly in Bill 36.

In part V, sections 28 and 29, the bill stipulates that "the minister may ... order a health service provider ... that carries on its operations on a not-for-profit basis to ... cease operating," or "to amalgamate with one or more" other "health service providers." This legislation does not apply to a for-profit health service, however. Why are for-profit providers exempt from such regulations? We are deeply concerned—in fact, we are outraged—that the not-for-profit providers are in danger of being squeezed out while for-profit providers gain more and more control of our health care system. We strongly recommend that all providers, whether they are for-profit or not-for-profit, be covered by this legislation.

The term "competitive bidding" is never actually used in Bill 36. The fact is, however, that a price-based, competitive bidding system in home care services, first introduced by the Conservatives, has been retained by the Liberals. As a result, non-profit home care providers such as the VON have lost out in the bidding wars to for-profit companies. Under such legislation, LHINs would have the power to allocate funding, and therefore services, to entities that underbid others. Since the government has supported the competitive bidding model in home care, why wouldn't we be concerned that the minister might include the same model in his strategic plan for the entire health system? We strongly recommend that Bill 36 be amended to ensure that the use of competitive bidding in selecting appropriate service providers be prohibited.

In the *Toronto Star* on June 29, 2005, Ian Urquhart asked Mr. Smitherman whether the LHINs might be considering an expansion of for-profit health care. Mr. Smitherman responded, "I wouldn't say that is a goal of this model. I wouldn't say that it's envisioned and therefore it's speculative." Urquhart described his response as "cryptic."

Ms. Futterer: Thank you for taking the time to listen to us today. The fact that you've made it possible for individuals and organizations from all over Ontario to take part in these hearings is encouraging. As we mentioned earlier, we appreciate the intent of Bill 36. We hope you will be able to use some of our recommendations in revising the act and that the Minister of Health and Long-Term Care will keep our concerns in mind as he prepares his strategic plan. After all, we must believe everyone sitting in this room today wants an improved health care system that meets the needs of all Ontarians. Thank you.

1500

The Chair: Thank you for your presentation. There is less than a minute each. Ms. Wynne, please.

Ms. Wynne: Thank you very much for being here. Two quick things: First of all, is it reasonable to you that within a local health integration area there would be a plan that would have particular services that might be offered by a variety of providers and that there might be some sort of process—you could call it a competitive bidding process—whereby the provider with the best capacity and ability to provide that service would be granted that service? Does that make sense? I'm talking about the non-profit, public providers. That's my first question.

Secondly, a number of groups have talked to us about including the principles of the Canada Health Act in the preamble. Is that what you are envisaging?

Ms. Mounstevan: We would like to see the Canada Health Act mentioned. Nowhere is it mentioned at all.

Ms. Wynne: And you want it in the bill somewhere.

Ms. Mounstevan: Yes, absolutely.

The Chair: Mr. Arnott.

Mr. Arnott: A number of groups have asked for that specific amendment, that there should be some provision in the preamble to make reference to the principles of the Canada Health Act, and that Bill 36 would conform to those principles. We'll be interested to see if the government brings forward such an amendment.

You expressed concern about three major issues. You suggest in your brief that the purpose of the legislation is to provide for an integrated health system. Then you asked the rhetorical question, "Why does it not include family doctors, dentists, optometrists and so on?"

Quite a number of doctors have come before this committee, and I think the Ontario Medical Association as well is in favour of the establishment of a medical advisory committee to be associated with each LHIN. Would you agree with the Ontario Medical Association that that would be desirable so that there would be an ongoing mechanism for input from Ontario's doctors?

Ms. Gerda Kaegi: I think the committee has heard from me before, but I will try to respond. Yes, in principle, but not exclusively. In other words, the advisory committees have to have a breadth of the range of service providers, and it has to be stipulated, in our view, that that breadth must exist, and it's got to go beyond the medical association.

The Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation here today. I'm glad to see that you came and that you raised your concerns and criticisms. I'm glad to see that you took on the minister head-on when he said that anybody who is a critic is wedded to the status quo. He also says that health care workers are only interested in keeping their jobs, as if people shouldn't worry about their jobs or the important health care services they deliver through those jobs.

In any event, let me get back to competitive bidding. The legislation deals with both for-profit and not-for-

profit providers—for-profit particularly in the long-term-care sector. So it's hard to imagine how you could have a scenario where you might have some kind of competitive bidding process just among the not-for-profits when the sectors that the LHINs are responsible for are bigger than that. Having said all that, you've referenced competitive bidding. It's not in the bill. If the government means what it says, you're suggesting that it should. Further to that, what are the concerns you have with respect to competitive bidding, and what could happen if indeed this was brought in to include not only home care, which it does now, but also any of the broad range of services that the LHINs will have responsibility for?

Ms. Kaegi: Competitive bidding has tended to drive down the quality of care. It's the lowest possible price for the service. It has led to lack of continuity and a drop in quality of service. There's lots of documentation and research that's been done in the area, and we feel it's been destructive. So we don't believe that competitive bidding, as it's carried out now, has been appropriate at all. I think what we're talking about is, look at the quality and the needs and the service provision that people have a record of providing, their links in the community. There are other ways of evaluating service providers rather than the dollar figure, which has tended to drive much of what's taking place. We use the example of the VON, which has disappeared in many communities, including the one that Mr. Arnott represents. They have been driven out, and it's been tragic.

Ms. Martel: They lost in my community too, after 80 years.

Ms. Kaegi: Yes, in many parts of Ontario.

The Chair: Thank you very much for your presentation.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair: The next presentation is from the Psychiatric Patient Advocate Office; David Simpson and Lisa Romano. Welcome. You can start your presentation whenever you are ready.

Mr. David Simpson: Good afternoon. My name is David Simpson. I'm the acting director of the Psychiatric Patient Advocate Office. With me today is Lisa Romano, legal counsel to the Psychiatric Patient Advocate Office. We'd like to thank the committee for its invitation and the opportunity to share our recommendations. You'll see that we've made some 36 recommendations in our submission. We're hoping that these recommendations will be adopted to further strengthen Bill 36 and the health care system in Ontario.

This legislation will bring about one of the most significant transformations of our health care system in Ontario, shaping and profoundly impacting how this and future generations will access care and treatment. It is because of the significance of these changes that we are here today.

What are our concerns? We are concerned about the availability of health care services throughout commun-

ities in Ontario. We are concerned about the accessibility of a full range of mental health services and supports to Ontarians in need of these services. We are concerned about the accountability of the Ministry of Health and Long-Term Care and the local health integration networks to the public by means of effective checks and balances.

What are the questions that we have about the proposed legislation? How will the new structure improve the delivery of health services in Ontario? How will the system be accountable to the people it serves? What rights-protection mechanisms are in place to protect not only the public but vulnerable populations such as those with mental illness? Why doesn't the legislation include rights-protection mechanisms reflecting a clear commitment to patients' rights? This would include such safeguards as an independent health systems advocate, a patient bill of rights, a transparent complaints process and a sunset clause that requires mandatory review of the legislation after a period of time. How will a system that has a local perspective take into account a provincial perspective? How will the power and authority of the minister and the LHINs be tempered with checks and balances that protect the public interest?

Let me begin by saying that we are supportive of the fundamental intent and purpose of this legislation but feel it could be strengthened via specific amendments for the benefit of all parties, including those with serious mental illness and addictions who will receive direct services under the proposed new structure. The proposed amendments would provide increased public protection, transparency and accountability. This is necessary because the LHINs are not accountable to the community but to the minister, and thus the necessity to have enhanced rights protection mechanisms included in the proposed legislation. We are here today to provide recommendations and offer solutions.

For the past two decades the Psychiatric Patient Advocate Office has provided independent advocacy and rights advice services to patients in the 10 current and divested provincial psychiatric hospitals in an effort to protect and promote their legal and civil rights. With over two decades of experience, we believe we are uniquely qualified to comment on the LHINs legislation, rights protection mechanisms, transparent complaint processes, transforming the health care system to better meet the needs of patients and the potential impact that it may have on our clients.

Although our experience within the health care system is specific to mental health and addictions, we believe that many of our recommendations are equally applicable to the broader health care sector and will lead to both enhanced system accountability and adoption of a client-centred, client-first and client-directed perspective.

The PPAO is supportive of the development of the LHINs, provided that a full range of mental health and addiction services, supports and treatment modalities continue to be available and accessible to patients, including both hospital and community-based programs.

This includes timely access to services available in the home community of the person, and where those services are not available, the LHINs must have a legislated responsibility to connect the person to the appropriate service they require. Moreover, clients must not be asked to pay for such services, as they should continue to be provided by a publicly funded system.

1510

In cases where the client is required to travel to another LHIN to access services, a system of reimbursement of expenses similar to the northern health travel grant must be put in place. Many individuals with mental illness may not have the funds necessary to travel outside their community to access services. Funding must also be made available to individuals who choose to access mental health and addiction services outside of their home community due to concerns regarding conflict with a service provider, confidentiality, privacy or the quality of care that they would receive in their home community.

Mental health has been described as an orphaned child of the health care system, and for this reason, care must be taken to ensure that mental health services are neither eroded nor inaccessible to patients. It's hoped that each LHIN will have a champion for mental health, mental illness and addictions. The provincial government must continuously monitor the LHINs to ensure that individual service delivery areas and specific services are not neglected, underfunded or simply abandoned.

We would also like to recommend that the Minister of Health and Long-Term Care form an advisory committee on mental health, mental illness and addictions to provide advice and consultation to both the minister and the 14 LHINs on issues related to this sector.

The process for engaging with clients: It would be helpful for the legislation and corresponding regulations to specifically articulate the process whereby community or citizen engagement is undertaken and how such consultations should be conducted. The process for community engagement must be developed in consultation with a broad range of stakeholders, and the proposed legislation must specifically define what the term means. Further, the legislation must clearly define the community engagement process and include a mechanism for reporting back to the community the results of the consultation process. This will heighten accountability and further the public interest by having a real and meaningful process defined in the law.

We're also of the opinion that Bill 36 should define in law the basic basket of services required to be provided by each LHIN as well as the reasons why these services should be available in each local community. This will generate greater public discussion regarding health services and the expectations of the community to be able to receive care and treatment close to home.

Enhanced rights protection mechanisms would also be available if the legislation appointed or introduced an independent health systems advocate. That would be an important step forward in transforming health care in Ontario. An independent advocate could access not only

individual complaints but systemic complaints. This environmental scanning would allow for the identification of emerging issues and trends with recommendations for the allocation of health care resources. The health systems advocate could report annually on the state of health care in Ontario and make recommendations both to the LHINs and the government on how to improve the system at large, while also reporting on the overall health of the system itself.

We also believe that Ontario should consider adopting and implementing a patient bill of rights for the health care sector. This again would heighten accountability and public awareness with respect to quality care, service delivery, outcomes and expectations, and provide guaranteed access to services.

We're also of the opinion that a complaints process should be enshrined in the legislation that specifically talks about timeliness, a fair process and a transparent process, with clear timelines and possible outcomes for resolution defined in the legislation.

In terms of commitment to consumer-survivor involvement, it's our opinion that the legislation should specifically mention the role of consumer-survivor in the mental health and addiction sector. It's also our opinion that the legislation should require that all in-patient mental health care programs have a consumer and family council that's fully funded and has autonomy. Consumers and families have a more extensive role to play and much more to offer than is currently recognized or acknowledged in Bill 36.

We would also like to see recognition and inclusion of peer support workers and peer support specialists in the legislation. This would send a clear message about their importance in a transformed health care system. It would recognize the value-added contribution the peer support workers could make to mental health and addictions programs and lead to peer support for all medical conditions being seen as important and endorsed by the community.

Again, we'd like to suggest that the minister develop a consumer-survivor advisory committee on mental health, mental illness and addiction that's parallel to the health professionals advisory committee.

The Chair: One minute left, sir.

Mr. Simpson: Last, transformation and devolution of decision-making to LHINs must also be supported by a transformation of how services are provided and how clients and patients are viewed by the system. It must have a recovery orientation and move away from a purely medical model of care provision. Once integrated, the health care system in Ontario must have a wellness and recovery focus, with a defined and shared philosophy of care. This made-in-Ontario model of care will result in an astounding transformation.

Working together, we can all contribute to a system that is responsive to individualized needs and provides the best care and treatment possible while respecting individual rights and heightening public accountability.

The Chair: Thank you very much for your presentation, sir.

The next presentation is from the United Association of Plumbers and Steamfitters, Local 46; Mr. Bill Signal. Is he here? No? All right, we'll go to the next one.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0N, IROQUOIS FALLS

The Chair: Is the Service Employees International Union on the line?

Interjection.

The Chair: Is anyone here who needs to speak to us?

The Clerk of the Committee (Ms. Anne Stokes): Shirley Cummings-Hall is here.

The Chair: Okay. Can we hear from Shirley Cummings-Hall, the 4 o'clock deputation? In the meantime, maybe you can get in touch with the next one, please.

Interjection.

The Chair: Oh, we've got it? Shirley, just have a seat, please.

Who do we have on the line, then?

The Clerk of the Committee: Ted Marcotte.

The Chair: Good afternoon, Mr. Marcotte. Would you please start your presentation. You have 15 minutes. Please proceed.

Mr. Ted Marcotte: Good afternoon. My name is Ted Marcotte, and I'm representing the Service Employees International Union, Local 1.0n, from Anson General Hospital in Iroquois Falls, and South Centennial Manor, also in Iroquois Falls. SEIU, Local 1.0n, represents about 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services across Ontario.

Bill 36, the Local Health System Integration Act, 2006, in its present form, will radically alter the kind of health care services Ontarians receive, how these services will be delivered, who will perform them and who will lose as a result of the integration, amalgamation and devolution of health care services. Contrary to the language of Bill 36, this legislation will remove any local control over health care and place the control of health care services solely within the power of the Minister of Health and Long-Term Care and the Ontario cabinet.

The Minister of Health and Long-Term Care professes his commitment to the Canada Health Act, but this legislation is an attempt to further circumvent the principles of the Canada Health Act. At the very least, the preamble and section 1 must contain specific commitments to ensuring that the principles of the Canada Health Act are maintained. As this bill now reads, every health care service not covered by the Canada Health Act will be subject to privatization.

1520

The government is moving this legislation forward without a strategic plan for the delivery of health care in Ontario in place. A provincial strategic plan needs to be in place before the LHINs can even start to develop their plans—sections 14 and 15.

SEIU Local 1.0n asks the members of this committee to delay third reading until this government has held broad consultations with all stakeholders. The Minister of Health and Long-Term Care must develop a strategic plan in consultation with the public. The plan must also include a human resources plan. I will say more about this later.

This legislation is flawed because its premises are based on cost-containment of health care services and not on ensuring Ontarians have equal access to quality public health care services. In effect, Bill 36 is nothing more than the Ontario Liberal government's cost-containment strategy. Privatization schemes that will reduce human resources costs is the route the government has chosen to take.

In 2003, little more than a month after the Liberal government was elected, in an economic update, the Finance Minister, Greg Sorbara, alluded to the fact that there must be a way to control the compensation and salary costs of the health care budget. The following spring, the health tax was introduced. Health care workers are now subsidizing their own wages, up to \$900 per year. Every hour a nurse works, 50 cents goes to the Liberal health tax. Apparently, the government believes health care workers can sacrifice even more.

In this section, I'll talk about the LHINs. They are undemocratic. LHIN boards are unelected. Each LHIN director, appointed by order in council, is only accountable to the Minister of Health and Long-Term Care. Sections 7 and 8 of Bill 36 must be amended to provide for the election of LHIN boards of directors. The compensation of LHIN boards must specify that all members of a LHIN are residents of their LHIN.

If it is the government's purpose to move towards greater local control and allow communities to determine local priorities—though we fail to see how this is possible, given the large geographic expanse of the LHINs and an unequal mix of large metropolitan centres dominating rural areas—it is essential that real control reside with local citizens, not those appointed by the Minister of Health and Long-Term Care. That this legislation will give greater control over health services to local authorities is just false. With the size of LHIN 13, how can nine people be local?

If Bill 36 passes in its present form, what chance would a small community have to decide what health services it wants when this community is lumped into a LHIN with larger metropolitan centres? Citizens in small communities will have little or no voice compared to large population centres.

Section 9 suggests LHIN board meetings are to be public, but what citizen could travel 200 kilometres or more to attend a board meeting? Has any of this been addressed so this would be looked after?

Section 16 states that the LHIN is to "engage the community." At what level? What community interests are to be taken into account, and to what degree? Reconsiderations of LHIN decisions, as outlined in sections 26 and 27, do not allow affected parties much time to

appeal—30 days. Will unions holding bargaining rights have the right to a reconsideration process? The very short time frame of any party to make a submission for reconsideration and to study the impact a LHIN board decision will have on local health services suggests the government wants to limit this appeal process.

Why does the government draw the line at the health care providers as defined in the act? Why are independent health facilities, physicians, laboratories and ambulances not included in this? Why are independent health facilities outside the scope of this legislation? Is it because ancillary services at these clinics can be charged to patients, and services these clinics provide can more easily be delisted?

The establishment of standalone specialty clinics belies the government's intention for greater local control over health care services. These independent health facilities could be operated as private clinics but funded by public health dollars.

We note also that a LHIN is to establish an advisory committee of health professionals, but physicians are excluded from this legislation. How can doctors act in an advisory role without being part of the entire health system?

Sections 14 and 15 of the act must be amended to allow for community control and input in the planning process.

That the LHINs at this point have no idea of what they are to do is highlighted by these examples. One: The chair and CEO of the Central East LHIN, speaking to the Campbellford Memorial Hospital's board of directors, said, "As this is our first plan, we expect the 14 plans to be pretty macro. By the time we get to our third annual plan, it'll settle out on a level of detail that'll be much greater than the first one will be"—Community Press Online, January 19, 2006.

The second example: A Sarnia Observer reporter tried to get an answer about LHINs from the people who are supposed to know. He spent a day trying to find out why the Ontario government is acting on legislation it hasn't passed yet. He claims he never really got a satisfactory answer. The new CEO of the Erie-St. Clair LHIN, Gary Switzer, told the reporter to call Toronto. A Ministry of Health and Long-Term Care bureaucrat refused to be quoted. MPP Di Cocco was finally reached and commented, "It's a work in progress and not a foregone conclusion that the bill will pass. It's very complex"—Shawn Jeffords, Sarnia Observer, January 6, 2006. If the bureaucrats and elected members can't tell us what is going on with Bill 36, why should the legislation pass until citizens know how it will affect their health care system?

As Bill 36 now stands, the underlying philosophy of the legislation is to ensure that any health services outside the Canada Health Act are open to privatization. This legislation gives near-dictatorial powers to the Ontario Minister of Health and Long Term Care. The Minister of Health will have greater control over the kind, type and amount of health care that is provided in each LHIN in Ontario.

Section 26 of the Act allows a LHIN to provide all or part of a service or to cease to provide all or part of a service; provide a service to a certain level, quantity or extent; transfer all or part of a service from one location to another; transfer all or part of a service or receive all or part of service from another person or entity; carry out another type of integration of services that is prescribed; do anything or refrain from doing anything necessary for the health service providers to achieve anything under any of the above listed, including transfer of property or to receive property from another person or entity.

Section 28 of the bill allows the Minister of Health to order a health service provider that carries out its operations on a not-for-profit basis to cease operation, to dissolve or to wind up its operations, to amalgamate with one or more health service providers, to transfer all or substantially all of its operations to one or more persons or entities, and to take any other action necessary to transfer property.

LHIN powers to order integrations are limited only by the fact that they cannot order health service providers to cease operations, dissolve or wind up, but what the LHINs lack in power, the Minister of Health can do.

Section 33 will allow the government to order health service providers to cease operating and—section 28—transfer their property. This leaves the door wide open to greater privatization of health care services. For example, a LHIN could require the transfer of health care services such as chronic care from a public hospital to a private, for-profit nursing home.

I'd like to talk about LHIN finances. The Ontario Liberal government promised it would deliver a balanced budget before the next election in October 2007. This legislation will make the promise a reality and the only promise apparently this government intends to keep. The only way this government can balance its budget is to take a big bite out of the health care budget.

No LHIN will be allowed to have an operating deficit. Each LHIN must make do with the monies allocated to it by the provincial government. A LHIN cannot borrow without the approval of the provincial government.

1530

The Chair: Mr. Marcotte, you have used the 15 minutes. Can you please conclude?

Mr. Marcotte: Okay. Bill 36 is a revolution in health care. There will be a lot of carnage left on the battlefield if this legislation passes.

As a union, we would like for you to reconsider passing this bill in March and to delay it until further consideration is done. Thank you very much for having me speak.

The Chair: Thank you very much, and you look lovely on TV.

Mr. Marcotte: Thank you.

The Chair: I understand that there is a friend of yours who is going to speak to us from the same studio, am I right? Can we speak with Judy Shanks?

Mr. Marcotte: Yes. They're ready to slide in, I believe.

The Chair: Thanks very much, sir. Mr. Marcotte, if you don't mind, if you can send to us your material by fax or e-mail we will be happy to share it with the rest of the committee—your presentation.

Mr. Marcotte: Okay. No problem.

The Chair: Thank you again. Good bye.

CANADIAN MENTAL HEALTH ASSOCIATION, NORTHEASTERN ONTARIO BRANCHES

The Chair: Ms. Shanks?

Ms. Judy Shanks: Yes, it is. Good afternoon.

The Chair: You can start your presentation any time you are ready. There's 15 minutes in total.

Ms. Shanks: Thank you very much. This is a presentation by myself, Judy Shanks, the chief executive officer, on behalf of the Canadian Mental Health Association branches in northeastern Ontario, which is made up of the Cochrane-Timiskaming branch, the Nipissing regional branch, the Sault Ste. Marie branch and the Sudbury branch.

The Canadian Mental Health Association branches located in northeastern Ontario are pleased to participate in the public consultations regarding Bill 36, the Local Health Systems Integration Act. We are non-profit health care organizations that deliver a wide range of mental health services to our communities. We routinely work with local agencies to assess the needs for mental health treatment and support, and have functioning partnerships with other health and social service agencies in order to deliver comprehensive recovery-focused services. Many of our programs are funded by the Ministry of Health and Long-Term Care; hence, our operations will be immediately affected by Bill 36 if it does become law.

First, we wish to congratulate the government for moving forward with the health system integration. We commend your courage in challenging the status quo in a fundamental service required by all citizens. We believe and support the enactment of the stewardship role for the Ministry of Health and Long-Term Care for the health care system. We also support health care management, strategic long-term planning and system accountability mechanisms being closer to local communities and health care partners. We look forward to working with our North East local health integration network to ensure equitable and effective health care delivery in our region. We recognize that system integration needs to be guided by province-wide, evidence-based standards for all types of health care, while at the same time being operationalized in a flexible manner so as to account for local diversity of population needs, available resources and unique community characteristics that shape health care delivery.

Bill 36 must serve as the strong foundation for integration of Ontario's health care system. The content of this bill is vitally important to each and every citizen. We need to take time and give careful consideration to the details of the bill so that they are clearly defined, functionally appropriate and balanced in terms of dem-

ocratic principles and rights. Undoubtedly, health care system integration within a framework of public accountability means there are and will continue to be very challenging and difficult choices to be made in terms of what, where and how health care services are delivered to Ontarians.

Bill 36 must ensure that health care system delivery and management occur according to best practice standards and processes across the province; all types of health care are equitably funded; and finally, the public has ongoing, transparent access and opportunities to participate in all levels of the health care system.

Collectively, we must take the opportunity presented in the passing of this important legislation to redress significant imbalances in our delivery of health care and place the focus on proactive and balanced models of health and health care delivery that embrace the mental health, emotional, physical and spiritual needs of Ontarians.

To this end, we wish to highlight six points relating to Bill 36 as it is currently drafted. We trust that these issues will be given full review by the standing committee on social policy. We have these specific concerns:

(1) Overall, the act is silent regarding the fundamental principles of health care in Canada enshrined in the Canada Health Act. How health system integration in Ontario will safeguard principles such as comprehensiveness, universality, accessibility, portability and public administration is not evident. A vague term, “acting in the public interest,” is the only principle encoded, and no means is provided as to how citizens may appeal policies which are not “in the public interest.” This leaves the door open to wide variations of interpretation and action on the part of governments and bureaucracies, including the ministry and local health integration networks. It offers little assurance or protection to Ontarians. We recommend that the bill more directly relate the health care system principles to health service integration.

(2) The role for the general public in the management of the health care system and in health integration decisions is largely absent in this legislation. All members of the LHINs boards are to be appointed by order in council. While all citizens may apply, government appointments are often made to include a select few who share the dominant political view of the day. Health care providers, funded by the Ministry of Health and Long-Term Care, are not eligible to be part of these boards, yet the same exemption is not in place for the private, for-profit health care providers. Overall, the total number of positions available on these boards, which will have expansive health care system management responsibilities in the amount of almost \$20 billion, is small. Other venues and opportunities for meaningful public involvement need to be defined in the administrative directives for the LHINs.

“Engagement of the public” is not defined in this act and is being left to possible definition by the less-scrutinized, regulation-making process. Again, this is a key principle that requires full explanation in the act to ensure that all Ontario citizens will be accorded the same

opportunities of engagement, frequency of engagement, and input on important, as opposed to mundane matters.

Community engagement needs to be fully recognized as a sustainable process fundamental to health care system operation. The present wording in the act places maximum emphasis on the responsibility of health service providers for community engagement. While this is both necessary and appropriate, this process demands adequate resources and skilled facilitators to ensure the general public becomes and remains informed. The same requirement for public engagement is not imposed on the LHINs structure. This is a significant oversight that must be addressed directly in the legislation.

(3) The degree of power awarded to both the Minister of Health and Long-Term Care and the LHINs through this legislation, with respect to health service integration decisions and orders, is almost absolute. The intent appears to be to provide a means to redirect health care funding dollars when health care providers are failing to meet required standards, and to respond to local and provincial integration priorities and decisions. While such punitive measures may be required, there’s no mention in the legislation of incentives or other positive measures that should be enacted to encourage health care providers to embrace the new standards that will be defined for Ontario’s health care system.

While expectations for health care delivery will increase significantly under the act—for example, public engagement, voluntary identification of opportunities to integrate and development of service plans that dovetail with LHIN and provincial strategies—there are only negative consequences defined for health care providers that fail to comply.

Furthermore, there appears to be little devolution of authority to the local levels of the health care system. The minister alone retains the right to make the decisions that would substantially restructure the health care system.

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(4) Reconsideration of integration decisions or orders is severely limited to one appeal during a 30-day period, and is only available to the affected health care provider. The health care provider may not have received any type of advance notice from the LHIN with regard to an integration decision. The provider would have to seek legal counsel, develop a challenge and present this to the LHIN or the minister. Thirty days is an insufficient amount of time to ensure due process.

The second issue relates to the stipulation that an appeal may only be launched by the affected provider. This runs contrary to the spirit of the overall direction to bring health services management and planning closer to the citizens of Ontario. The general public, as well as people served by the affected agency, deserve full and open access to integration decisions or orders as well as the right to be heard in an appeal of such decisions. While the political process might be the default appeal for citizens faced with this situation, the timing for appeal prescribed by the act would inhibit effective access and response via an elected member and the Leg-

islative Assembly. Fair and reasonable access and longer time frames are called for in this appeal process.

(5) A critical omission in this draft legislation is the lack of a diversity provision for the board, operating structure or accountability mechanisms in order to safeguard the interests of marginalized populations served by Ontario's health care system. This oversight is of utmost concern to agencies like ours, as we serve people with serious mental illness who daily experience systemic discrimination with the health care system and the larger society. Without diversity provisions, there is a high risk that the level of systemic discrimination will increase and harm our most vulnerable citizens in most need. Not only could this trigger challenges under the Canadian Charter of Rights and Freedoms, but it also runs contrary to values of our society that adhere to the principle of universal health care.

(6) By extension, marginalized populations are also at further risk because the legislation is lacking in detail as to the criteria that the LHINs and the minister will use to effect integration plans and decisions. Such criteria need to be fully transparent to ensure that community-based health care providers and larger providers of acute health care services are to be treated on equitable terms for funding and any changes in operation. This detail needs to be explicated in the legislation. As well, the legislation must ensure standard implementation across the 14 LHINs in Ontario.

At this time, we wish to thank you for your consideration of our brief. We look forward to seeing the redrafted legislation. The Canadian Mental Health Association of northeastern Ontario will be prepared to assume its full role in a reformed provincial health care system.

The Chair: Thank you, Ms. Shanks. We received the e-mail of your deputation. We thank you for that. We will be distributing it to the members.

There are less than three minutes. I'll start with Mr. Arnott, if there are any questions.

Mr. Arnott: Ms. Shanks, I don't have any questions. I want to thank you very much for your presentation and for offering this committee the view of your organization, the Canadian Mental Health Association of northeastern Ontario. It's been very helpful. Your comments were well taken. Thank you so much.

The Chair: Ms. Martel.

Ms. Martel: Thank you, Ms. Shanks, for your participation today from my part of the world. I appreciate that.

You have really focused on a lot of the omissions around community input, community participation and community ability, for example, to respond to integration decisions or orders. What are you worried about in this respect? You have stated very clearly that this seems to run counter to the stated objective in the bill, which is to deliver care closer to home with the community involved in that. You've certainly pointed out a difference between what is stated as an objective and what the reality is when you look at the provisions of the bill. Why are you worried about that?

Ms. Shanks: From our perspective, it still sounds like the minister has a lot more control. For it to be given to

local communities and local input, we feel we've lost sight of that in terms of how the legislation is being presented. At a local level, we feel we have been cut out of that process, even in terms of the election of the boards.

Ms. Martel: I think you're right. Thank you.

The Chair: Ms. Wynne.

Ms. Wynne: Thank you very much for being with us. I want to address the issue you raised about boards excluding health care workers but not participants in the for-profit sector. The general government public appointment guidelines will cover that kind of conflict-of-interest situation, so it wasn't necessary to be explicit about that in the legislation. Does that make—

Ms. Shanks: Fair enough, but what I'm concerned about is the fact that there won't be the experience from the field to have input into the LHINs.

Ms. Wynne: That's why we've got the health professionals advisory committee set up, and that's why the community engagement section is in the legislation. We want that formalized input from the health professionals advisory committee, but we also want ongoing dialogue between the LHINs and the community. That's why that section is there.

A lot of groups have said to us that they would like to see that community engagement section expanded and made more specific. I think you'll see amendments coming forward from all sides on how to do that.

Ms. Shanks: That certainly covers the point.

The Chair: Thank you, Ms. Shanks, for calling us from Timmins, and also Mr. Marcotte. Have a nice evening.

SHIRLEY CUMMINGS-HALL

The Chair: The next presentation is Shirley Cummings, finally. Thank you for coming. I know you were ready to speak to us an hour ago, and we thank you. In fact, we are ahead 15 minutes.

Ms. Shirley Cummings-Hall: My name is Shirley Cummings-Hall. I am a personal support worker.

Bill 36 threatens to dehumanize, degrade and destroy the employees like myself and our clients. It will guarantee a competitive bidding model in health care forever. Cheap labour will cause employees to work longer, more arduous hours.

In my opinion, most of the employees in my field are immigrant women. Most of us are single grandmothers and single mothers. Then, there will be no one at home to supervise the children. The streets will become their friends. This leads to guns, gangs, etc. The longer hours and cheaper wages we work for lead to stress. Stressful employees cannot operate and give optimum service to the clients.

I work for \$13 an hour, few benefits and no pension. I use my car and I'm only given 21 cents per kilometre, which does not cover the cost of gas. Because of the cost factor to get to my clients, I'm also subsidizing the client's care plan. Millions of dollars have already been saved by exploiting underpaid workers like myself.

As a personal support worker, I'm also a psychologist, a nurse, a domestic and sometimes even a plumber. I love my job, but how long can I continue to subsidize Ontario's home care system? The only people who will benefit from Bill 36 are the fat cats who can afford to open nursing homes and retirement homes and agencies. Again, they will have a cheap labour force, and most of these people are like myself. This bill must ensure that health care workers like myself are protected. The committee must make amendments to ensure that there is no competitive bidding process in the home care sector.

Ms. Caplan said that competition is good, but research has found that it's not really so. It doesn't work. I can remember the SARS epidemic, when most of the contract workers did not show up for work. The fundamental elements of a home care delivery process must be continuity and quality of care that the patients receive.

1550

My union, SEIU Local 1, in its brief to this committee, pointed to the need for a human resources plan for the health care sector. That plan must ensure home care workers have equal employment rights with those enjoyed by all other Ontario workers. It must guarantee home care workers these conditions:

- Guarantee a new agency to continue to employ the employees of the home care agency they plan to replace. Many people lose their jobs and work for less whenever a new agency takes over.

- Guarantee to recognize and provide the same working conditions, seniority, wages and benefits the employees had with the displaced agencies. Wages and benefits must reflect the prevailing union or highest wage rate within a CCAC's geographical jurisdiction.

- Recognize a union representing the employees of the home care agency that is being replaced. The successful home care agency in the RFP process must be bound to any existing collective agreements with the union that represented the employees with the previous agency. Only a stable, professional and fairly compensated workforce will ensure Ontarians that they will have quality, as well as continuity, of health care service.

As I said before, the most exploited people in home care are immigrant women. We are always the burden bearers of a developed society like this. The people who have drafted this legislation have no idea and no understanding what it means to be a dedicated, loving and compassionate caregiver to society's most vulnerable—seniors and the disabled—and the only reward we get for that is poverty wages. It appears to me that the bottom line is what the Minister of Health said in his opening remarks to this committee: "We must stop the cost curve from rising any further in the health care sector." Apparently, the only cost this government wants to contain is wages, such as mine.

I must repeat: Millions of dollars have been saved from people like myself. I go to a job for two hours and end up spending four because of the condition of the client. This country and most developed, westernized countries are built on the backs and the blood, sweat and

tears of people like myself. I'd appreciate some understanding and some empathy on behalf of people like myself. Thank you.

The Chair: Okay. There is a minute-plus each, and I'll start with Ms. Martel, please.

Ms. Martel: Thank you, Ms. Cummings-Hall, for your presentation today about how you are impacted now as a health care worker under competitive bidding. You will know that, regrettably, even though Ms. Caplan did a report on competitive bidding, she was very clearly given a mandate that did not include recommending getting rid of competitive bidding as a model in home care. So we are stuck with this very destructive model in home care. Because the bill before us doesn't prohibit very specifically this model from being used in other sectors, my fear is that we will see an extension of what has been so destructive in home care to other sectors of health care that the LHINs are going to be responsible for.

I have said to the government very clearly, "If it isn't your intention to extend competitive bidding to other sectors, then put it in the legislation." We will see whether the government brings that forward as an amendment when we start to deal with amendments next week. But you have certainly clearly shown to the committee what it's like to be a worker in this sector. I don't know how people live on the wages that they do in home care. You are, if I might say this—don't take this the wrong way—actually one of the fortunate people because you at least have a union. I don't know what workers are doing out there in home care who don't even have union representation these days. I have no idea how they're making ends meet.

I just wanted to thank you very much for bringing your personal story forward to show why competitive bidding should have no place in home care.

The Chair: Thank you. Ms. Wynne.

Ms. Wynne: Thanks for being here. The reality is that what Ms. Martel is suggesting in terms of this legislation actually wouldn't help your situation. I think what we have to do is take a broader look at the conditions of health care workers. For the first time ever, there actually is an assistant deputy minister in our ministry looking at health human resources. The conversation that your organizations need to have with, that man in the ministry—Dr. Josh Tepper is his name—is a really important one, because even if we were able to do what Ms. Martel is asking in this legislation, it wouldn't change the situation for you.

What I think is really important is that we need to make sure you and the people who do the kind of work you do get a better deal, and that the guidelines and conditions are better for your work, because your work is vital. It's the caregiving work that I absolutely understand is done by women, and it's done by immigrant women. It's a burgeoning field, because as people age, and we have an aging demographic in this country, we need more people doing this work and it needs to be valued, quite frankly. Outside of this legislation, there's a lot of work that has to be done.

Thank you for coming and for sharing your point of view with us.

The Chair: Mr. Arnott.

Mr. Arnott: I just want to compliment you on your very effective and powerful presentation today, because I think it's given all of us on this committee a great deal to think about. Hopefully, as the government moves forward with the amendments to Bill 36, some of what you've said will be reflected in their response.

Ms. Cummings-Hall: Thank you very much.

Ms Carroll: I think that's why we find it so important that the competitive bidding process is addressed in the legislation. We don't want to see other health care workers end up in the type of situation that these workers go through. It's very stressful for them.

The Chair: Thank you very much. The next presentation is from CARP: Canada's Association for the Fifty-Plus. Is there anyone here? The next one is Empowerment Council. Is there anyone here from Empowerment Council, or from the Ontario Federation of Community Mental Health and Addiction Programs?

If not, we'll take a five-minute break, if you don't mind. We'll try to be here at 4:05 and see if anyone does show. We are about 16 minutes ahead, so we'll just wait a few minutes. Thank you.

The committee recessed from 1558 to 1609.

CARP: CANADA'S ASSOCIATION FOR THE FIFTY-PLUS

The Chair: We will convene again. We'll start with our 4:15 presentation from CARP: Canada's Association for the Fifty-Plus. Mr. Gleberzon, the floor is yours. You have 15 minutes.

Mr. William Gleberzon: Thank you very much for the opportunity to express CARP's views on Bill 36 on the LHINs. If you don't know who we are, CARP is Canada's Association for the Fifty-Plus. We have 250,000 members in Ontario and about 400,000 across the country. Our mission is to promote and protect the rights and quality of life of older Ontarians and older Canadians. Our mandate is to develop practical recommendations for the issues we raise. CARP reflects the concerns of consumers, patients and caregivers—the general public—and that's the perspective I'll talk from this afternoon.

CARP believes that the LHINs are a step in the right direction in that they represent what we regard as a somewhat limited integrated approach to health care. For example, doctors, paramedics—ambulance services—and family caregivers are not part of the networks. We believe that these people should all be partners in the new move towards the integration of health programs and services, which we see as a very positive step.

The LHINs should be strengthened by making them truly local through community engagement. This can be achieved by the establishment of an advisory committee drawn from the population served by the LHINs, consisting of young and seniors, family caregivers, rural

and urban residents, multicultural individuals, and the like. The advisory committee could be modelled on the provision in subsection 16(3) of the bill that service providers must engage the community when developing and setting priorities for the delivery of health services.

Accountability by the LHIN boards and staff should include regular reports to this advisory committee as well as to the minister. CARP also recommends that the legislation be amended to enjoin the minister to ensure that appointments to the board include individuals who understand the specific needs of those who live within the LHIN boundaries. As you know, the LHIN boundaries in many cases are quite large and encompass a large and diverse population. The CEO and top managers of the LHINs should be appointed by the minister from among the best available candidates, with appropriate skills to understand the needs of those who live within the LHIN boundaries. As the new staff for the LHINs are hired, staffing in the Ministry of Health and Long-Term Care's central office should be examined to identify unnecessary duplication of functions and/or candidates for transfer from the central office to the LHIN bureaucracy.

The role of CCACs should not be expanded beyond their current roles as contemplated in part VII, section 39 of the bill. Moreover, we find that the language in this section is vague and too open-ended. In fact, the role and function of CCACs should be reviewed, we believe, in light of the concerns raised in earlier public consultations regarding CCACs. The experiences for many clients and family caregivers are that CCACs are not providing services in an effective and efficient manner, and we keep hearing this from many of our members.

The focus of case managers within the CCACs must be on the welfare of clients rather than the CCACs' bottom line, and they must not operate so as to force family caregivers to become the real case managers by default. It's for that reason we believe that family caregivers should be part of the advisory committee that we're suggesting. CCAC board members should include representatives from the local communities within the individual LHINs, although the CEO and other staff can be hired from among the best candidates, regardless of residency.

The authority of the minister to suspend operations, integrate or amalgamate not-for-profit health providers on the advice of the LHINs must be revised, we believe. In order to ensure full transparency and accountability to the communities within the LHINs boundaries, the minister and the LHINs must justify any of these actions to the advisory committee, which would have the right to appeal the decision as part of the explicit public consultation process noted in part V in regard to the devolution of any "power, duty or function" of the minister or his or her delegate to the LHIN. And this appeal process should be increased to six months from the current 30 days, which we believe will just not give enough time.

Thank you very much for this opportunity. I welcome any comments or questions.

The Chair: We have at least a few minutes each. I'll start with Ms. Wynne, please.

Ms. Wynne: Thank you very much for coming today. A couple of things: I just wanted to be sure you were aware that in this legislation a return to community boards is in place for the CCACs. You're of that?

Mr. Gleberzon: Yes, we are.

Ms. Wynne: Would you like to comment on—

Mr. Gleberzon: We think that's a good move, obviously. Very much so.

Ms. Wynne: You're very happy about that.

Mr. Gleberzon: Yes, we are.

Ms. Wynne: Okay. Because I think that addresses your concern about the representatives of the individual communities.

Mr. Gleberzon: For the CCACs but not for the LHINs.

Ms. Wynne: Yes, for the CCACs. As far as the LHIN boards, what we envisage there and what is happening already is that people from the LHIN are being appointed to the board. In other jurisdictions, what we found is that people weren't coming forward to stand for election, and so the public appointment process, which has specific guidelines in place, is intended to get the expertise and the regional representation on those boards. That's why we've opted for that.

The last thing I wanted to talk about was your last point about increasing the reconsideration process to six months. I think the concern there might be the slowing down of integration processes. Can you comment on that?

Mr. Gleberzon: Our concern is that decisions—for example, in York region a decision was made regarding the local and well-established service provider, which was cut out of the RFP process. There was quite a hubbub about that. We hope that won't happen again. We're suggesting six months, but the point we're trying to make is more than 30 days, to allow the community time to organize and make sure that whatever its concerns are, they're heard.

The Chair: Thank you. Ms. Martel.

Ms. Martel: Thank you for your presentation today. Let me go to page 4, where you say, "The role of CCACS should not be expanded beyond their current roles." The committee has heard two different perspectives about that, to share that with you. Of course, the Association for Community Care Access Centres came and said they would like to have more of a role in the system as system integrators, their case managers doing not only home care but, I gather, other services. They said the minister had made that invitation to them at a conference, I think, that he spoke at and they did a proposal in response. So we've heard from them saying they should have a bigger role and hoped the minister agreed with that. And we've heard from primarily the community mental health sector and CHCs also saying that system navigation shouldn't be the purview of one particular agency or set of agencies. Is your concern about the role of CCACs and that it not be expanded has

to do with what you hear from families and those who use the system about what is inadequate in the provision of care now?

Mr. Gleberzon: That's correct, yes.

Ms. Martel: Do you have some more specific examples that you could share with us?

Mr. Gleberzon: I can. I think it's summed up in the statement, where we talk about case managers that "they must not operate so as to force family caregivers to become the real 'case managers' by default," and they should not be guided simply by the bottom line. We understand that there is a limit to what can be spent, but, as I'm sure you know, for families that are in distress, it is an extra distress when they don't get the kind of service they need when they need it. That's the concern about the case manager, who is not always providing that kind of service. The family members must turn into advocates. Many of them find they're stressed taking care of their loved one, and here they have additional stress being added.

That's part of the concern we have there and that we've heard from a lot of our members. My colleague Judy Cutler, had she been able to join us today, could have talked about her own personal experience in that regard. She ended up taking care of her brother, who was both schizophrenic and had cancer, and ended up trying to navigate the system that she, because she knew something about it, was able to navigate somewhat easily, but certainly not the way a case manager could have. It was a constant battle.

The other issue you raised was about the mental health side of things, because the concern is—again, I'm not sure of the actual role of the CCACs in this, but it's something that has to be looked at very seriously, and that is the gap between mental and physical health that a lot of families encounter, in home care particularly. These are the kinds of concerns such that if we're going to integrate the system—and we think that's the only way to go and the best way to go; we're 100,000% behind it—it should be integrated from the bottom so families really can get the service they need, and when these situations arise that don't fit very nicely into little boxes, the system is able to accommodate the needs of those people.

The Chair: Thank you very much for your presentation.

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EMPOWERMENT COUNCIL

The Chair: The next presentation is from the Empowerment Council; Jennifer Chambers. Good afternoon. Please have a seat. You have 15 minutes total for your presentation and potential questions.

Ms. Jennifer Chambers: Thank you. The Empowerment Council is a non-profit organization that is dedicated to acting as a voice for people who have been in the mental health and/or addiction systems, particularly the clients of the Centre for Addiction and Mental Health. The Empowerment Council's board, general membership

and staff consist of people with this personal experience. Our catchment area is Ontario, consistent with that of the Centre for Addiction and Mental Health. We are fiscally responsible to CAMH, but responsible only to our membership for our policies and practices. This is the way we keep the integrity of our independent voice representing clients.

The proposed Local Health System Integration Act is to be credited for its recognition in legislation of the critical role of community engagement. Our concerns then become, how are “community” and “engagement” defined in practical terms? Community must consist primarily of those citizens of Ontario whose health is at stake. In mental health and addictions, this means those who have had personal experience of these systems. It will not do to substitute the voice of others. Study after study has shown that prejudice-based beliefs and discriminatory treatment of our members is pervasive throughout society. People considered to be mentally disturbed or having addictions are frequently found to be the least wanted of any social group, be it in the general public, as employees or even in the health care system itself.

“Individuals with mental illness and addiction also face discrimination and rejection by service providers both in the mental health system and the broader health care system, and discrimination by policy-makers and the media.” This is a finding of the mental health committee of the Senate that was chaired by Michael Kirby and recently toured Canada. For this reason and because the most effective health care provision is that which meets clients’ self-identified needs, it is critical to have people who have personally experienced mental health issues and addictions have a substantial voice in decisions affecting our lives. There is considerable research evidence indicating the importance of meeting clients’ self-identified needs rather than the needs identified by health service providers. To quote from one such study, “Outcomes were not strongly related to either the amount or types of services people received. However, good outcomes were strongly linked to consumers having their needs met.... The results also demonstrated that good outcomes were more closely linked to consumers’ perspectives of needs than in their case managers’ perspective.”

“Good outcomes were also linked to whether consumers felt empowered—had some control over the treatment process and were involved in decisions regarding their services, medications and housing.”

The same is true on a policy as well as an individual level. It will not do for the LHIN to engage only those who plan or provide services and consider that to be a legitimate process for valid decision-making. This requirement on a LHIN policy level also applies to the accountability provisions that LHINs should apply to all funded services. Each must be required to have meaningful involvement of its clients in governance and evaluation.

In the recent interim report of the standing Senate committee on social affairs, science and technology, it was noted that:

“A major criticism of mental health services and supports and addiction treatment in Canada is that it is largely organized around (and often for the convenience of) providers, not patients/clients. Rather than the system adapting to meet their needs, it seems that individuals with mental illness and addiction are expected to adapt to fit into the system and access services and supports only when and where the system can provide them.

“This rather damning observation is confirmed in several provincial reports that have acknowledged that the delivery of mental health services and supports and addiction treatment needs to be more strongly person-oriented. To improve the quality of patients’/clients’ lives, safe, timely and effective treatments, services and supports should be coordinated around the needs of individuals with mental illness and addiction.”

They note that their international comparative analysis has found that other countries have managed to engage in such a process.

The support that the Centre for Addiction and Mental Health offers for an independent client voice is by far the exception rather than the rule in Ontario.

The US National Council on Disability observed that “policy-making based on input from experts, and that excludes participation from people labelled with psychiatric disabilities themselves, results in wasteful and ineffective one-size-fits-all public policy that doesn’t efficiently meet the needs of those it is intended to serve.”

“The National Council on Disability has also concluded that one of the reasons public policy concerning psychiatric disability is so different from that concerning other disabilities is the systematic exclusion of people with psychiatric disabilities from policy-making.”

The method of engaging community will predict how meaningful the community’s contribution will be to health care planning and delivery.

I would like to go over the recommendations of the Empowerment Council briefly.

I’d like you to know that a previous Liberal government formed a legislative subcommittee, known as the Graham commission, that toured Ontario in the most comprehensive consultation with the people of Ontario that ever took place on mental health services. It came out with a number of recommendations, and I urge committee members to go directly to the community mental health legislation subcommittee report which details the recommendations that came directly from the consultation. I don’t recommend the later reports, which reflect influences that came into play other than the direct voice of the people of Ontario.

Recommendation 12 of that committee, of that report, is one that we fully endorse: “that consumer-survivors participate fully in the mental health system—that one third of boards and committees should be consumer-survivors, chosen by consumer/survivors.”

We recommend that Bill 36 more specifically describe the formal mechanism for community engagement and that health care clients be identified as integral and substantial participants in any engagement process.

We recommend that the legislation require the creation of standing committees of the LHIN board that report directly to the board.

We recommend that a standing committee on mental health and addictions be specified in legislation, at least one third of which consists of clients or former clients of addiction and mental health services nominated by clients at a consultation for this purpose. Actually I should have said “as part of a consultation process,” as we later detail that. Any body representing mental health issues must also contain representatives of advocacy organizations, as the individual’s experience of rights deprivation is uniquely prominent in the mental health system.

We recommend that this same requirement as described in the Graham committee’s recommendation be required of all funded mental health and addiction services.

We recommend that another standing committee of the board be formed that is essential to good health care decision-making—a committee of persons with disabilities. Reflective of the percentage of need in the population and the specific quality of mental disability issues, we recommend that such a standing committee include at least two members representing people from the mental health system and two people representing people from the addictions systems. This should include some representatives of self-help initiatives for persons with disabilities, including advocacy organizations, as the well-being of the organizations that are run by and for us also affects our well-being.

The recommended process by which clients are selected to represent their community was exercised in the creation of the Advocacy Commission, an organization stemming from the work of Father Sean O’Sullivan in his report *You’ve Got a Friend*. It entailed the democratic polling of groups and organizations in order to elect representatives who, in turn, nominated commission members.

The Empowerment Council would also like to endorse the recommendations made in the submission to this committee by the Ontario Peer Development Initiative.

We commend the combined efforts of the Centre for Addiction and Mental Health, the Canadian Mental Health Association and the Ontario Federation of Community Mental Health and Addiction Programs for their support of client involvement.

I’m missing my last page. I hope no one else is missing it.

The Empowerment Council also agrees that mental health and addiction funding must be protected and enhanced, as is clearly required by all reviews of this health care sector.

This is a great opportunity to do things right, creating a health care system that enhances social as well as personal well-being. By its very structure and processes, the LHIN is poised to become a determinant of health, and we hope it will be a good one.

The Chair: Thank you. We have a minute-plus each, and I’ll start with Mr. Arnott, please.

Mr. Arnott: Thank you very much for your presentation. It was very good. I want to ask you about community engagement and how you feel the LHINs should engage their communities in discussions as they move forward. Exactly how would you want that to happen?

Ms. Jennifer Chambers: I think the creation of standing committees with representatives on the committees who have been selected by the community should entail a regular feedback process between those representatives and the community. One way this has been done is to have public consultations to which members of the community are invited and particular issues are polled in the community, both initially as setting out some values and principles in which the committee can operate and then on occasion about some more specific, detailed decision-making.

The Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation today. You recommended to us the report of the subcommittee that was established by the Legislature some time ago, and I appreciate the recommendation for us to read it, but I wanted to ask as well about some work that was done even more recently than that, which seems to have gone into an abyss. Those were the task forces that were established on mental health, the nine regional task force reports that were submitted to the government. I don’t know where they’ve gone. I don’t know where the recommendations are. I’m assuming that on each of those task forces there were consumer-survivors who played an active role. Maybe you can tell us what your knowledge is of where they’ve gone and how all of that work might actually impact on this process, because that seems to be the most recent good work that was done on what is needed for mental health reform in Ontario.

Ms. Jennifer Chambers: I would strongly recommend that there be a standing committee on mental health and addictions and that that committee review the reports you just mentioned: the Mental Health Implementation Task Force reports. A great deal of effort and consultation did go into the creation of those reports, and I think they would have a lot of value, save a lot of time and reflect a lot of community involvement if they were reviewed.

The Chair: Thanks very much for your presentation.

Ms. Wynne: Do I get to—

The Chair: Of course. Ms. Wynne wants to ask you a question.

Ms. Wynne: Thanks very much for being here. You noted on page 3 of your document, “It will not do for the LHIN to engage only those who plan or provide services and consider that to be a legitimate process,” and then you reference the Ontario Peer Development Initiative. If I recall—and I don’t have their presentation in front of me—they talked about the engagement of families in consultation. So I’m assuming that you’d be looking for some explicit mention of the importance of families in that community engagement process. Is that a fair assessment of what you’re looking for?

Ms. Jennifer Chambers: No. I represent the clients, the people who have been clients in the mental health and addictions system, not the families. I leave it to families to best represent themselves and their wishes in this regard.

Ms. Wynne: Okay. I think the point that was being made, though, was that families and clients are often intertwined, especially in this sector, so that it's necessary to include the family. It's not that you're not supporting that; it's just that you were advocating on the client side at this point. Is that right?

Ms. Jennifer Chambers: Yes, although I'd actually say that it's not uncommon for families and clients to take opposite positions on issues, so while I would not seek to be exclusive of any group in Ontario, I wouldn't necessarily serve my community well to recommend a prominent role for every family organization that exists in the mental health sector.

Ms. Wynne: So for you it's the client groups, the individuals, who need that prominent role.

Ms. Jennifer Chambers: Yes, the people most directly affected.

The Chair: Thank you again for coming tonight.

The next presentation is not in the room yet. It's the last one. We will wait until he does attend or until 4:45, which means 13 more minutes, unless he comes before that. In the meantime, it's newspaper or BlackBerry time. Thank you.

The committee recessed from 1634 to 1646.

The Chair: It is 4:46. The person who should be speaking to us has spoken to us in other locations. Therefore, unless you disagree, I think we can bring an end to this meeting. Before doing that, unless there is any disagreement—Ms. Wynne.

Ms. Wynne: No, there's no disagreement. I just wanted to make a very brief comment. This has been a very long series of committee hearings, and I just wanted to say that I think the process of listening to the more

than 200 people—individuals and representatives of groups—has been a really worthwhile one. Even though many common themes came out throughout the seven days, as the hearings went on those themes were embellished and clarified. We have a lot of material to work with in terms of coming up with amendments.

Sometimes it's easy to underestimate the public, and an experience like this really allows us to be clear on how much wisdom and information there is in the public. So I want to thank everybody who presented before us and the communities behind them that support their views. And thank you very much to the opposition members for such a civil and fruitful process.

Mr. Arnott: Mr. Chairman, I just want to express my appreciation to you, Anne Stokes and the other staff who have worked so hard over the course of these hearings. It's been an interesting process, and we certainly look forward to next week when we do the clause-by-clause.

Ms. Martel: My thanks as well to the many people who made presentations, particularly those who drove a long way to come here. It was good as well that the committee actually made some accommodation to hear from people from the northwest and the northeast in a different way than having them travel. My thanks as well to all of the staff who were involved, both those who travelled with us last week and those who were involved at Queen's Park, for making this happen.

The Chair: Thanks to you, to Ted and to everyone else for what you have done for this very important piece of legislation. It's not over yet, but I feel better hearing that there will be amendments. Hopefully, all of us will feel much better when the amendments are heard and dealt with. At the end of the day, we are going to improve the system somehow. The issue I see is how much we're going to improve it.

Thank you to all, and to staff in particular. Goodnight.

The committee adjourned at 1650.

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Monday 13 February 2006

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Lundi 13 février 2006

**Standing committee on
social policy**

Local Health System
Integration Act, 2006

**Comité permanent de
la politique sociale**

Loi de 2006 sur l'intégration
du système de santé local



Chair: Mario G. Racco
Clerk: Anne Stokes

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 13 February 2006

Lundi 13 février 2006

*The committee met at 1557 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

The Chair (Mr. Mario G. Racco): Good afternoon and welcome to our first day of clause-by-clause. Today we have the standing committee in clause-by-clause considering Bill 36, An Act to provide for the integration of the local system for the delivery of health services.

There is a package of motions which was distributed on Friday afternoon. I understand that the NDP has already given us a number of amendments. Are there any other amendments from anybody else? The clerk has received some amendments from the NDP. Are there any comments, questions or additional amendments from anyone, and if so, to which section?

Ms. Kathleen O. Wynne (Don Valley West): Not at this point.

The Chair: But they will be added.

Ms. Wynne: Yes, Mr. Chair. At this point, I do not have any new amendments, but there may be some at a later date.

The Chair: Yes, that's fine. Thank you for letting us know.

Now the clerk needs to put together these amendments provided to us by the NDP, so I will have to recess. How much time do you need?

The Clerk of the Committee (Ms. Anne Stokes): I don't know—10, 15 minutes.

The Chair: Which would you prefer?

Interjection.

The Chair: Fifteen, so we don't rush the clerk. We will be back at about a quarter after four. Thank you.

The committee recessed from 1600 to 1644.

The Chair: I am told that the meeting can start. I thank you for your patience.

I was asking when we ended if there were comments or any amendments in addition to the ones we have. Are there any additional amendments at this time?

Ms. Wynne: Are you asking, will there be other amendments that come forward?

The Chair: Yes.

Ms. Wynne: There may be one or two that will come forward but not now. That would be tomorrow.

The Chair: Therefore, we can start with the first amendment, on page 1, is it?

The Clerk of the Committee: No, on page 7.

The Chair: Can I have somebody move it on page 7?

After second reading, an amendment to the preamble is admissible only if made necessary by amendments to the bill. Therefore, we will begin with section 1 and deal with the preamble at the end.

Again, I ask the same question. Are there any comments, questions or amendments on section 1, which is on page 7 of your package? Madam Martel, I believe it's your amendment. Do you wish to read it?

Ms. Shelley Martel (Nickel Belt): I have a question, Mr. Chair. I can understand leaving the preamble, but why wouldn't we start, then, on page 3, part I, "Interpretation," section 1?

The Chair: Would the clerk assist me on that, please?

The Clerk of the Committee: Page 3? It's part of the preamble. Page 7 is the first one of these.

Ms. Martel: Are you talking about page 7 of the bill?

The Clerk of the Committee: No, page 7 of your package, the original package.

The Chair: We have 48 amendments, I believe.

Ms. Martel: Got it.

The Chair: We all have this package. It's NDP motion, section 1, page 7. That's what we are dealing with. It's up to the NDP to start. Okay?

Ms. Martel: Thank you, Mr. Chair.

Mr. Kim Craitor (Niagara Falls): I don't have that.

The Chair: If you don't have it, we'll get one for you.

The Clerk of the Committee: You don't have a package?

Ms. Wynne: We've got the actual package.

The Chair: Yes, but they should—don't they have this?

The Clerk of the Committee: No.

The Chair: Oh, that's only for me, then. Okay. I can manage better. That's why—

Mr. Craitor: I still want it anyway.

The Chair: You can start.

Ms. Martel: I move that section 1 of the bill be amended by adding “in a manner consistent with the public interest” after “to provide”.

If you look at the purpose of the act, which is where we’re starting from today, it says that “The purpose of this act is to provide ...” and it lists a number of things that the bill is supposed to do for Ontarians. This motion is being moved to make it clear that along with some of the other things that are listed there, “public interest” should appear right at the top in terms of why we’re doing this and who we’re doing this for. This was a recommendation that was made by both the Ontario Nurses’ Association and OPSEU.

The Chair: Is there any debate on the motion? If there is no debate, then I will now put the question. Anyone in favour? Anyone against? The motion does not carry.

PC, page 8: Madam Witmer, please.

Mrs. Elizabeth Witmer (Kitchener-Waterloo): I move that section 1 of the bill be amended by striking out “health services, coordinated health care” and substituting “high-quality health services, coordinated health care in local health systems and across the province.”

That was an amendment that was requested by the Ontario Hospital Association and also the Council of Academic Hospitals of Ontario in order that there would be access ensured to effective and high-quality patient care. Obviously, that needs to be central to the implementation of the LHINs and that also must be of paramount concern as the LHINs make their decisions. So it’s important that this principle be clearly articulated in the legislation.

The Chair: Is there any debate on the motion? If there is no other debate, I will now put the question. Those in favour of the amendment? Page 8 carries.

Madame Martel, page 9, please.

Ms. Martel: Because “public interest” was not defined—I was trying to add “public interest” into the purpose of the act so it would be a principle. I also then had to provide a definition for “public interest.” Now the clerk is going to tell me whether or not, because the original motion was voted down, this is now out of order.

The Chair: Just one moment. The clerk is going to check and provide an answer.

1650

Ms. Martel: I can read it into the record while you decide, if you want to do it that way.

The Chair: Go ahead.

Ms. Martel: I move that section 1 of the bill be amended by adding the following subsection:

“Public interest

“(2) Nothing shall be considered to be consistent with or in the public interest for the purposes of this act if it would be contrary to,

“(a) the protection of medicare through the maintenance and expansion of existing publicly funded health services;

“(b) the prohibition of two-tier medicine, extra billing and user fees;

“(c) the principles of public administration, comprehensiveness, universality, portability and accessibility as provided in the Canada Health Act;

“(d) the achievement of a patient-centred system that ensures access to health care based on assessed need and not on an individual’s ability to pay;

“(e) access to a continuum of both clinical health and community health care for every Ontarian, including, but not limited to, primary care, public health care, long-term care, home care based on assessed need and community mental health care;

“(f) the protection of the rights of health care workers, including, but not limited to, minimum compensation standards, representation by a trade union and rights that have been conferred under a collective agreement; or

“(g) any value set out in the preamble to the act.”

If I might just add to what I said at the outset, I felt it was in our interest to ensure that the purpose of the act was to support the public interest. It was necessary to have a definition for “public interest,” and the definition that I put forward makes it clear that the principle of the bill should rest on protecting medicare, prohibiting two-tier medicine, on the principles of the Canada Health Act and the other details that I’ve articulated. I think those would be important in terms of what we’re doing, why we’re doing what we’re doing, and who we’re doing this for.

The Chair: Thank you. Do I have an answer to the question? There is material in the bill making reference to “public interest.” Therefore, it’s in order.

Ms. Martel: So it is in order.

The Chair: It’s in order. The bottom line is it’s in order.

Ms. Martel: Thank you. Then I hope the committee will support it.

The Chair: Is there any further debate on the motion?

Ms. Wynne: Only that my position is that, in the purpose of the act, the guidelines are on how we’re seeing public interest are laid out, so I won’t be supporting this motion.

The Chair: Any further debate? If there is none, then I will now put the question: Those in favour of the motion? Those opposed? The motion does not carry.

Shall section 1, as amended, carry? Those in favour? Those opposed? Carried. Section 1 carries.

Section 1.1 is new. Page 10: Mrs. Witmer.

Mrs. Witmer: Section 1.1: I move that the bill be amended by adding the following section:

“Consistency with purpose

“1.1(1) Every decision, plan and regulation made under this act taken under this act by a local health integration network, by the minister or by the Lieutenant Governor in Council shall be consistent with the preamble, with the purpose of the act as set out in section 1, and with the objects of the local health integration networks set out in section 5.

“Same

“(2) Where a decision or plan to which subsection (1) applies is in writing, the decision or plan shall be accom-

panied by a written statement setting out key facts demonstrating that the decision or plan is consistent with the preamble, with the purpose of the act as set out in section 1, and with the objects of the local health integration networks set out in section 5.

“Same

“(3) A regulation to which subsection (1) applies shall include a statement setting out key facts demonstrating that the decision is consistent with the preamble, with the purpose of the act as set out in section 1, and with the objects of the local health integration networks set out in section 5.”

The rationale is, accordingly, that these recommendations were actually made by the Brewery, General and Professional Workers’ Union. They believe that the preamble acknowledges the importance of transparency and accountability in clause (d). It doesn’t, however, contain any mechanism to hold the LHINs and the minister accountable. Also, it fails to incorporate accountability and transparency into its operational provision, so they have supported the inclusion of this recommendation.

The Chair: Is there any debate on the motion?

Ms. Wynne: Yes. My position is that this would be a really overly burdensome bureaucratic process that would mean it would be very difficult to move forward with the changes that this bill envisages.

The Chair: Any further debate? I will now put the question. Anyone in favour of this amendment? Anyone opposed? The motion does not carry.

Section 2: Ms. Wynne, page 11, please.

Ms. Wynne: I move that the definition of “accountability agreement” in subsection 2(1) of the bill be amended by striking out “a local health integration network is required to enter into with the minister” and substituting “the minister and a local health integration network are required to enter into”.

The Chair: Any debate on the amendment?

Ms. Wynne: What this does is change the definition of an accountability agreement to be consistent with 18(1), and provides that there is a mutual obligation on the minister and the LHIN to enter into the accountability agreement.

The Chair: Any further debate? If there is no debate, I will put the question. Anyone in favour? Opposed? It carries.

Mrs. Witmer, page 12, please.

Mrs. Witmer: Are we doing 11a?

The Chair: I’m sorry, yes. We have 11a, 11b and 11c. I will go to 11a, which is Ms. Martel, please.

Ms. Martel: I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘community’, in relation to a local health integration network, means,

“(a) every person who received services from the local health system,

“(b) every resident of the geographic area of the local health integration network, and

“(c) every health service provider that provides services in the geographic area of the local health inte-

gration network, whether the provider is funded by the local health integration network or the ministry;”

There are a number of references, of course, to community in the bill. There was much concern raised during the course of public hearings about how broad or how narrow community is going to be regarded by the LHINs. This makes it clear that, in the broadest sense possible, the LHINs should be looking at this definition of community as they start dealing with posting of information, consultation etc.

The Chair: Any debate?

Mrs. Witmer: I’m certainly going to be supporting this amendment. I think it does capture and give a comprehensive definition of community. I think it’s important that it includes the people who are going to be receiving the services from the local health system.

The Chair: Any further debate?

Ms. Wynne: We’ll be bringing forward amendments in section 16 which will deal with this issue.

The Chair: Any further debate? If none, I will now put the question. Anyone in—yes, Ms. Martel.

Ms. Martel: I have a question, though. If I look at—and somebody’s going to correct me if I’m wrong; there are lots of folks here today. I’m looking for the definition of community. I understand that there are going to be changes in section 16, but I’m assuming they’re changes around notification and input. I’m trying to find the definition of community to understand who’s going to be affected by those changes.

The Chair: Ms. Martel, are you asking a question of staff or the political—yes, Ms. Wynne.

Ms. Wynne: I’d ask Ms. Martel to look at government motion 52.

Ms. Martel: “‘Community’ includes”—I see what you’ve done. So that’s the only place it appears? You’re not putting it in the definitions section?

Ms. Wynne: It’s in the “Community” section.

1700

The Vice-Chair (Mr. Khalil Ramal): Now we’ll put the motion to a vote. Those in favour? Those opposed to the motion? The motion is not carried.

The Chair: The motion doesn’t carry. Okay. The next one is 11b. I believe that again is from you, Ms. Martel.

Ms. Martel: I move that subsection 2(1) of the bill be amended by adding the following definition:

“‘First Nation programs and services’ means all existing and future health-related programs and services directed primarily at First Nation communities and citizens, including, without limitation, those programs and services funded in whole or in part under the 1965 welfare agreement and those programs and services funded in whole or in part by the federal government of Canada.”

We heard a number of presentations from representatives of First Nations, at both the individual community level and provincial organizations. This amendment came to us as part of a package of amendments from the Union of Ontario Indians, so I move it on their behalf.

The Chair: Any debate on the motion?

Ms. Wynne: I'm not in a position to support this amendment, because I really don't know what the impact would be. There hasn't been time to analyze it, and it could have a quite far-reaching impact, so I'm not able to support it at this time.

The Chair: Any further debate? If there is none, I will ask for a vote. Anyone in favour of the amendment? Anyone opposed? The amendment does not carry.

The next one is from Mrs. Witmer, 11c.

Interjection.

The Chair: Subsection 2(1); otherwise, I'll give you my page.

Mrs. Witmer: I move that subsection 2(1) of the bill be amended by adding the following definition:

"'health,' in relation to an individual, includes both the physical and mental well-being of the individual; ('sant  ')

This is an amendment that has been requested by the Canadian Mental Health Association as well as the Centre for Addiction and Mental Health and the Ontario Federation of Community Mental Health and Addiction Programs. A March 2005 study by CAMH found that as decisions about funding are devolved from the central government, as is happening here, to regional decision-making bodies, there was a greater likelihood of mental health and addiction funding being lost due to what we know to be the case, the public's predominant focus on physical health needs as opposed to mental health needs.

They have requested this, and I strongly support this. I fought for this in Bill 8 as well. We need to recognize the importance of mental health and addiction services. We have to explicitly recognize it in the legislation, because mental health services are equally as important and essential to the health of Ontarians as those that focus on the physical health needs of people. That's why we've chosen to support their request.

The Chair: Any debate?

Ms. Martel: I'd support that request. I also have an amendment to the preamble, which we are dealing with later, which also makes a reference to a broader definition of "health," including physical, mental and social well-being. So I support it both in the preamble and in the section that Mrs. Witmer is moving now.

The Chair: Any further debate?

Ms. Wynne: The reason I'm not supporting this amendment is that in fact we don't have in this bill a list of the definitions of "health," or we don't explicitly talk about the components of health. We're talking about health in the broadest terms. If we include mental health, we need to be looking at what that longer list would be, so we're going to stay with the broad definition of "health," which is inclusive.

The Chair: Any further debate? If none, we'll take a vote. I will now put the question. Anyone in favour? Anyone opposed? The motion does not carry.

Page 12, Mrs. Witmer, please.

Mrs. Witmer: I move that the definition of "integrate" in subsection 2(1) of the bill be amended by adding the following clauses:

"(f) to improve the continuity of patient care within and across local health integration networks,

"(g) to increase collaboration among health service providers within and across local health integration networks,

"(h) to increase information within and across local health integration networks."

This is an amendment that came to us and was requested by the GTA/905 Healthcare Alliance. They are looking at this definition of "integrate," as written, which would ensure that integration decisions are taken with an eye to improving the system and patient care in Ontario. They're hoping this could be supported because they feel that the current definition doesn't speak to that in respect to Ontario.

The Chair: Any debate on the motion?

Ms. Wynne: I'll just say that we're focusing on the process of integration as opposed to the outcome of integration, so that's why we won't be accepting this motion.

The Chair: Any further debate?

Ms. Martel: I guess I can understand that, but I would be worried about the outcome after all of this, what this is going to lead to, where we're going to end up. That's got to be as important as the process to get into it in the first place. With all due respect, I don't understand that rationale.

The Chair: Any further debate? If there is none, I will now put the question. Anyone in favour? Anyone opposed? That's not carried.

Page 13, Mrs. Witmer, again.

Mrs. Witmer: I move that subsection 2(1) of the bill be amended by adding the following definition:

"'service' includes,

"(a) a service or program that is provided directly to people,

"(b) a service or program, other than a service or program described in clause (a), that supports a service or program described in that clause, or

"(c) a service in respect of which a health service provider receives funding from a local health integration network under subsection 19(1). ('service')"

This is a motion that was requested by the city of Toronto and also the Ontario Long Term Care Association. It's a multi-part amendment. First, it moves the definition of "service," as set out in section 23 of the legislation, and puts it in section 2(1) so that it has an application to the entire bill. If this motion is going to be adopted, it will be moved at the appropriate time to delete it, section 23, from the bill. This is required because, as written, the definition of "service" we currently have applies only to part V.

Section 21, which does not currently have a definition of "service," enables a LHIN to require a health service provider to submit to an audit of its accounts and financial transactions. LHINs should not have the ability to audit at will the entire financial status of a multi-service provider. This ability should be limited only to those aspects of an organization's function for which it

receives funding from a LHIN, so not the whole organization.

Secondly, this amends the definition of “service” for greater clarity, so that only those functions for which a provider receives funding from a LHIN are subject to an audit. LHINs should not have the ability to audit at will the entire financial status of a multi-service provider. This ability should be limited only to those aspects of an organization’s functions for which it receives funding from a LHIN. Again, this is coming from the city of Toronto.

Finally, the definition of “service” is amended so that the current part (c) of the definition is struck. Adopting this amendment will remove the ability of a LHIN to force a back-office integration that could unintentionally undermine the viability of an organization.

1710

As you know, in the long-term care sector, the majority of homes are part of multi-facility organizations such as chains, or they may be under the jurisdiction of a municipality, such as I know in my own community, the region of Waterloo. They are already maximizing back-office efficiencies through group purchasing and common procedures and processes. That’s the rationale for adding the definition we have here. It’s on the request of both, as I say, the city of Toronto and the Ontario Long Term Care Association.

Ms. Wynne: I think we deal with part of this in another section. I understand that Mrs. Witmer isn’t satisfied with the definition of “service” staying in section 23. I’m going to have to ask staff to comment on the auditing portion of this.

The Chair: Can staff have a seat at the front here, please. May I have your name, please?

Ms. Tracey Mill: Tracey Mill. I’m the director of the LHIN legislation project with the Ministry of Health.

The Chair: Thank you. Can you answer the question, please?

Ms. Mill: The question was with respect to the auditing provisions and the requirement or the ability for LHINs to audit any financial transactions. This is really just to ensure, again, the accountability for any public funds that are going to a health service provider.

Mrs. Witmer: Are they going to have the ability to audit a multi-service provider?

Ms. Mill: For those funds that are provided by the LHIN, as accounted for through the accountability agreements and the service accountability agreements that would be negotiated with those health service providers.

Mrs. Witmer: But not the entire organization?

Ms. Mill: It depends on how that organization might be organizing its finances. If those finances are commingled with other aspects of their businesses, again, it’s in order to ensure accountability of public funds. They may need to look at those other aspects of the organization’s functions or business.

Mrs. Witmer: So you could look at everything within the city of Toronto? This is their concern.

Ms. Mill: All I can say is that it’s to ensure there is an ability to identify and have appropriate financial report-

ing on any public funds that are given to that organization. If that organization’s accounting practices would have funding intermingled or commingled with other funding that it receives, then in order to ensure accountability, the LHINs would need to be able to look at those financial reports.

Mrs. Witmer: I guess that’s a concern—the scope—that has been expressed by both the city and the Ontario Long Term Care Association. There doesn’t seem to be any restriction at the current time, and that’s why we have supported them and tried to clearly define the scope of the audit of the particular service. Right now it appears that they can do almost whatever they want.

This gives the government a tremendous amount of latitude in auditing parts of any organization, whether it’s a multi-service provider in the long-term-care sector or a municipality that delivers services that would come under the auspices of the LHIN. That’s of tremendous concern to people as to the new and expanded powers this gives to the government.

Ms. Wynne: Mr. Chair, could I ask a question? Are you done?

Mrs. Witmer: Yes, go ahead, Kathleen.

Ms. Wynne: Could I just clarify? Is that accurate, that there would be a new power to audit a whole organization, or would it be that the auditor would have the opportunity to look at the finances to determine the extent to which the entity it was auditing was related to the larger organization? I just need to understand why we’re maintaining it this way.

Interjection.

Ms. Mill: Sorry; I’m just clarifying that. The powers that would be given to the LHINs in terms of auditing right now are not any different than the ministry’s current powers to audit agencies that we’re funding. The intent is not to expand any current authorities that we have; it’s simply a recognition that the funding and the accountability relationship will now be, if the bill is passed, between the LHINs and the health service provider. It’s really what the ministry would do in this instance now.

Ms. Wynne: So it’s no expansion of power that should be threatening the city; it’s a transferral of power from the ministry to the LHIN.

Ms. Mill: Yes.

Ms. Wynne: Thank you.

Mrs. Witmer: Can you guarantee that there is absolutely no change in the ability of any municipality to perform this audit function or, in the case of the long-term-care sector, these multi-facility organizations, such as some of the chains?

Ms. Mill: The policy intent and what is meant to be reflected in the legislation is not to change the current situation with respect to the audit capacities.

The Chair: Any further questions? There are not. Any further debate on the motion? There is none. Now I will put the question. Those in favour of the amendment? Those opposed? The amendment does not carry.

The next one is page 14. Ms. Witmer, please.

Mrs. Witmer: I move that section 2 of the bill be amended by adding the following subsection:

“Public interest

“(1.1) In this act, the public interest in health care includes interest in,

“(a) timely access to local health care;

“(b) continuity of health care;

“(c) good coordination of local health services;

“(d) quality care and treatment of individuals;

“(e) quality management and administration of health service providers;

“(f) sustainability of the health system;

“(g) efficient and effective management and delivery of health services;

“(h) maximized patient mobility;

“(i) maximized patient ability to make choices about his or her own health care;

“(j) promotion of a strong, stable and appropriate health services workforce;

“(k) efficient and effective integration of provincial and local health systems;

“(l) provincial plans and priorities for the health system; and

“(m) any other prescribed matter.”

This is an amendment that has been requested by a number of presenters: the Ontario Hospital Association, the Canadian Hearing Society and the GTA/905 Health Care Alliance. In fact, some individuals have recommended some very specific wording.

What we're trying to do here is ensure that subsections 26(1) and 28(1), which govern the making of integration decisions and orders by LHINs and the minister, make reference to the public interest. As there is no definition of public interest in the bill as currently written, there is a concern that the interpretation of the phrase will be left up to the LHINs and the minister. So the definition of “public interest” that we are speaking to here is very similar, if you would compare, to what presently appears in the Public Hospitals Act and also in the Commitment to the Future of Medicare Act.

What this definition does is it serves to ensure that patient care and community needs, which this bill is all about, are given due consideration and do provide safeguards against what may be perceived as arbitrary decision-making. That is the rationale for this definition of the public interest.

The Chair: Any debate on the motion?

Ms. Martel: I'm supporting the amendment, although Ms. Witmer will understand when I say I like my definition of public interest better. But that's all right.

I just thought it was broader; sorry, Elizabeth.

Mrs. Witmer: That's okay, Shelley.

1720

Ms. Martel: You've got to have some kind of definition here. Right now, all that section 26 says under “Required integration” is that this will happen, a LHIN will make copies available to the public, “if it considers it in the public interest to do so.” Well, who's defining that? Who's setting those parameters? Who's responsible for that framework? The last thing I want is to see 14

different LHINs have different definitions of public interest.

The second thing I don't want to see is that the definition be so useless as to, frankly, not apply at all and that decisions can be made willy-nilly without any kind of understanding of what that means with respect to the provision of services, people's access, whether the Canada Health Act is even considered, whether the principles that were articulated in Bill 8 are being upheld etc.

You didn't like my definition of public interest but you'd better get some kind of definition of public interest in this act if there's going to be any kind of uniform standard by which the boards of LHINs make some of these decisions.

The Chair: Any further debate?

Ms. Wynne: Just to comment. I think I've already commented that the purpose clause lays out the guidelines around public interest for this bill. We're also going to be bringing an amendment to the preamble that references the Canada Health Act and the Commitment to the Future of Medicare Act so the principles embodied therein apply. So I won't be supporting this motion.

Ms. Martel: Can I just ask one question? If a LHIN is to determine what is in the public interest, they're to look at section 1 and take from that what they should base their decisions on? I've got to tell you, there's not much there that would leave any kind of uniform standard across LHINs for making the kinds of decisions that they're going to be making about some of these services.

I'm looking at the interpretation, but I just fail to see what it is in that particular section that is going to result in a uniform definition or uniform principle being applied or a principle being applied that really takes into account those kinds of factors that should be in the public interest—access, people having to travel, what that means for workers who are disrupted etc. Those are all items that should be taken into account through this process, and I don't see where in the bill they are going to be taken into account.

Ms. Wynne: Again, I think that many of the things that Ms. Martel is talking about will be captured by the principles of the other pieces of legislation that are in place in the province.

Mrs. Witmer: Do you know what? I think this is rather frightening that we would not include a definition of public interest in this particular piece of legislation, which has such far-reaching consequences for both patients and communities in Ontario.

We are going to see—and Ms. Martel has made reference to it—some very arbitrary decision-making on the part of 14 different LHINs and possibly the minister. I would think, when we're moving forward and giving so much responsibility to these LHINs, we need to clearly articulate what the public interest definition is in this piece of legislation and provide some safeguards for both patients and communities in Ontario.

Ms. Martel: It's not as if we don't have some definitions of public interest already. There's a definition in the Public Hospitals Act. That may be where this has been pulled from, and I apologize that I don't know that

for sure. But my recollection on Bill 8—and someone will correct me if I'm wrong—is I think we spent a lot of time in Bill 8 sorting out a definition for public interest for that particular piece of legislation. So I don't even know why we wouldn't use a definition that the government, I believe, used in a previous bill that the Legislature dealt with; that is, Bill 8.

Mrs. Witmer: I can speak to that. This definition of public interest that we have put in place here is similar to that of the Public Hospitals Act. It's also similar to Bill 8, the Commitment to the Future of Medicare Act. So it's not as though this motion is new or different. I don't know why the hesitation to include it here.

Ms. Wynne: I just refer folks to the preamble and to the objects. It's in those two sections that we lay out what we mean by best public interest and the guidelines around how the services should be provided.

The Chair: Any further debate? If there is none—

Ms. Martel: Can I have a recorded vote, please?

Ayes

Arnott, Martel, Witmer.

Nays

Craiton, Fonseca, Leal, Rinaldi, Wynne.

The Chair: That does not carry.

Shall section 2, as amended, carry? Those in favour? Those opposed? Carried.

Section 2.1: Ms. Martel, page 15, please.

Ms. Martel: I move that the bill be amended by adding the following section:

“Aboriginal rights

“2.1 This act does not abrogate, derogate from or otherwise affect,

“(a) any aboriginal or treaty right that is recognized and affirmed by section 35 of the Constitution Act, 1982; and

“(b) the fiduciary obligation of the government of Canada to provide quality health care to First Nations peoples.”

A bit of background here: This amendment along with the next one that's going to follow it were amendments that were shared with the committee in the presentation that was made by the Union of Ontario Indians last week. They were also shared, in terms of sentiment if not the actual wording, in a presentation earlier in the week that was made by the Chiefs of Ontario. We had clarification with other aboriginal organizations that a non-derogation clause, for example, would be absolutely necessary to make it clear that nothing in the LHIN legislation, as proposed, was going to undermine or abrogate treaty and constitutional rights.

I am putting these forward and I'm seriously requesting the committee's support because—I think I have a copy of the amendments that the government is putting forward in this regard. If I'm wrong, I apologize, but I'm

fairly certain that what I got from the chiefs is a reflection of the government amendments, which are very limited. One says:

“(2) The minister shall establish the following councils:

“1. An aboriginal and First Nations health council to advise the minister about health and service delivery issues related to aboriginal and First Nations peoples....”

“(3) The minister shall appoint the members of each of the councils established under subsection (2) who shall be representatives of the organizations that are prescribed.” I'm assuming those are going to be aboriginal organizations.

Under a different section, section 16:

“(1.3) In carrying out community engagement under subsection (1), the local health integration network shall engage,

“(a) the aboriginal and First Nations health planning entity for the geographic area of the network that is prescribed;”

I can tell you that in letters I have received, and I am assuming others have received, First Nations organizations, at least this letter coming from the Union of Ontario Indians, make it very clear that “the present amendments as received by members of the task force are not acceptable.” There were other criticisms raised in the bill, but that was the very last line and made it very clear that what was put to them by the government was not acceptable.

Perhaps something has changed since Thursday last, and then again maybe something hasn't. My strong recommendation is, we heard very clearly that First Nations, both community members and also provincial leadership who are elected to their positions, felt very strongly that the handling of this legislation by this government was sadly lacking at best, especially in light of the government's new approach and also the blueprint for the First Ministers, which sets out how aboriginal people are supposed to be consulted and drawn into discussions about aboriginal health. So it seems to me that the least we can do is agree to some amendments that they actually put forward.

The process was already a very bad process and a very bad way to start a new relationship. The amendments that I gather—and someone will correct me if I'm wrong—were given to the chiefs, they have stated in a letter to us, are not acceptable, and I think it's high time that the committee actually agree to some amendments that were put forward by aboriginal organizations themselves. I think to do any less is just going to make what is already a very bad situation a whole lot worse.

1730

The Chair: Any debate?

Mrs. Witmer: We will be supporting this amendment that has been put forward by the NDP, as well as the next one, in regard to the aboriginal community. We have received numerous letters from the First Nations, as probably other members have as well, indicating their disappointment with the provincial government on the

handling of this Bill 36, because regrettably there was a report that had not been tabled at the time this bill came forward.

They have some very strong reservations about the commitment this government made to them. I think they feel betrayed in the way Bill 36 has landed on the table and really does not deal with the whole issue of what they say are matters such as LHINs that should be managed on a government-to-government basis. That has not happened. They make it very clear that First Nations are not stakeholders, and yet that's how the government has attempted to treat the First Nations. So I think it is important that we respect the original government commitment and try to live up to it. For that reason, I would very strongly support the two amendments that the NDP have here.

The Chair: Any debate?

Ms. Wynne: First of all, I want to say that I'm not a lawyer. I want to make that clear. The minister has been in conversation with both the aboriginal groups and the groups from the francophone community, and the amendments that we're going to put forward are the ones that the minister has deemed to be appropriate.

I will put forward the arguments for why we're not supporting other amendments, but as a member of this committee and a member of the government, taking advice from legal advisers and from the minister, I have to rely on that advice, because those are the people who have been having the face-to-face conversations.

On the issue of this particular amendment, my understanding is that this would be redundant, because the rights that are to be protected here are already protected under section 35 of the Constitution. That's why in this case, we won't be supporting this motion.

The Chair: Further debate?

Mr. Ted Arnott (Waterloo-Wellington): I was very impressed with the number of presentations that were made to this committee by First Nations organizations and individuals. There is obviously a very serious concern because of the lack of consultation while the bill was being drafted. While the parliamentary assistant may offer this committee some reassurance that the government is going to look after the interests of those people who are concerned about this issue, given the track record of the government in the lead-up to the introduction of Bill 36, I don't share her confidence. I think this amendment that has been brought forward by Ms. Martel is in the public interest and would ensure that, as a committee, we're seen to be responding to the legitimate concerns that the First Nations organizations put forward.

I would encourage the government members to give serious consideration to supporting it. Hopefully they will, and if there's some indecision on their part, perhaps they'd be willing, if they're thinking of voting it down, to stand down this vote, for consideration, perhaps tomorrow. I'm just offering that as a suggestion. I would hope that they will give it serious consideration.

Ms. Martel: A couple of points: I'm not a lawyer either. I'm not sure that I understand the rationale. The

Constitution Act is a federal piece of legislation. I would hope that if portions of it can be applied to provincial law to make it clear what aboriginal rights are and how they can be protected, then we should be looking at doing just that, to make it very clear in this provincial piece of legislation that there is nothing we are doing as a province that will undermine treaty rights. I don't understand all the legal niceties of it. If it's redundant, that says to me that it's not going to have an impact one way or the other, so let's put it in the legislation and at least respond to one amendment that was put to us by a broad cross-section of First Nation communities and provincial organizations that came before this committee.

The second thing I'd like to say is that the two amendments that I understand the government is going to put forward were sent to aboriginal organizations, they were asked for their comments and they got a letter back saying, "The present amendments as received by members of the task force are not acceptable." We are clearly not responding to the concerns that were raised by aboriginal people, first during the course of the public hearings and with respect to all of the consultations that went on when this bill was introduced. We were told they were many and we were told by aboriginal organizations that they weren't very satisfactory, so what the government is actually planning to bring forward are amendments that aboriginal organizations have already told this committee are not appropriate, are not enough and are "not acceptable."

Thirdly, here's what the letter also says. This is a February 9, 2006, letter: "The Union of Ontario Indians are concerned that the province of Ontario has failed to properly consult with the First Nations of Ontario on this sweeping legislation that has a genuine possibility of impacting negatively on the aboriginal, inherent and treaty rights in health of every First Nations member in the province of Ontario." That's a pretty strong concern that's being raised. It's a serious criticism that's being levelled at this government. I think we should take it to heart. We have had a bad process already with respect to First Nations' participation in this legislation. We clearly heard that from people who were involved at a technical level on the task force and from Chief Phillips, who was a task force member. That was well documented for us, and it was reiterated in the public consultations.

So for goodness' sake, can we at least do something right during the course of this bill and actually pass an amendment that First Nations want, an amendment that clearly says that nothing in this bill is going to undermine their treaty or health care rights? I don't think that's too much to ask. Frankly, I think if we don't do this, it will make a process that has been really bad a whole lot worse, and I just don't know why we'd want to go down that road.

The Chair: Debate?

Ms. Wynne: I'm actually going to ask staff to comment in a second on this. I think that it doesn't make anybody on this side happy that people aren't happy that we haven't reached an agreement. That's not something that pleases us, but the reality is that we've had con-

versations, the minister has been in conversation with the aboriginal and francophone communities, and these are the amendments that they and staff have deemed to be the most appropriate in terms of implementing the local health integration networks. The amendments that you refer to that we're bringing forward put in place an ongoing dialogue on the delivery of services to the aboriginal community. Having said that, there is a complicated relationship between and among the provincial government, the federal government and the aboriginal community, and that relationship is not going to be untangled with one piece of legislation. I think that the ongoing dialogue is important.

I'm going to ask staff to comment on the redundancy and the constitutional issue here, if that would be okay.

Mr. Robert Maisey: My name's Robert Maisey. I'm legal counsel with the Ministry of Health and Long-Term Care and the Ministry of the Attorney General. I can't comment on the process pieces, but I'll try to comment on the legal issues. It's a little unusual to have clauses like this in provincial legislation, partly because the bill has to be consistent with the Constitution Act of 1982. So the section may not have any additional legal meaning, but by putting it into an act like this, it suggests that there may be additional legal meaning and it's unclear what that legal meaning is. For example, it's not certain what rights could be affected by this bill, so having a clause like it in the statute suggests that there is something that is affected. The concern is that that would lead to litigation over what those rights might be.

1740

Ms. Wynne: Could I just be clear, then? In other words, if we put this in, there would have to be some longer explication of exactly what those rights were. That's a complicated process that we don't usually include in provincial legislation. Is that—

Mr. Maisey: That's a fair comment. It potentially changes rights or adds to rights that don't exist. It's just unclear what this clause means.

Ms. Wynne: Thank you.

Ms. Martel: Are treaty rights not defined already?

Mr. Maisey: Treaty rights would have to be defined with respect to what the treaty is, to my knowledge—which treaty applies to which aboriginal First Nation people.

Ms. Martel: But treaty rights have already been outlined in law, depending on which First Nation you're talking about or which grouping of First Nations, whether it's treaty 3 or treaty 9, right?

Mr. Maisey: I think there's a lot of litigation over what those rights are. In our consultation with various people, there may well be, but as far as I know today, we're not aware of treaty rights in Ontario that give health rights. Again, it comes back to that this section in a statute dealing with health issues, not land issues or resource issues, may not add any rights or clarify any legal entitlements.

Ms. Martel: Except you'd be aware of treaty rights with respect to NAN that impact the province because

NAN First Nations are signatories, along with the provincial and federal government. They are unique in that respect. They have rights that were entered into along with the province of Ontario. So in terms of rights, I think at least with the NAN communities, those are more explicit because they are signatories to a treaty that would involve both provincial responsibility and federal responsibility to those First Nations.

Mr. Maisey: I'm sorry. I'm not personally aware of that particular treaty. I was informed that we were not aware of health rights that would be part of a treaty.

Ms. Martel: We have a difference of opinion, I think. I'm not a lawyer. I appreciate your explanation, but my argument is that because NAN communities, which are primarily in northeastern Ontario up to the James Bay coast, were signatories to a treaty not just with the federal government but with the province, they more than any other group—and I'm not trying to undermine other aboriginal groups—actually do have some rights around health care, because health care is both provincially and federally mandated.

Mr. Maisey: As I said, I'm sorry, but I'm not aware of the particular content of the treaty in question. I was informed that we didn't have treaty rights that spoke specifically to health care.

Ms. Martel: Okay.

The Chair: Excuse me. Could I have Mr. Wood comment on this, please?

Mr. Michael Wood: I'd like to make a comment from the perspective of legislative drafting. If we were to put a section in like this, it would raise the question as to why we don't put this type of section into other legislation. Rights under the Constitution apply and affect the federal government and the provinces anyway. As I say, if we were to put this in here, it would somehow suggest that, unless you saw this in every single piece of legislation, somehow rights in the Constitution did not bind the province.

The Chair: You still have the floor.

Ms. Martel: I guess I'd respond—and again, I'm not a lawyer, so I'm sorry if I'm being tedious, but rights that were granted to aboriginal people are a little bit different than rights granted to other people. You're talking about a founding people that signed treaties. I have amendments for francophones too because I want to see them participate more fully in the process, but with all due respect, the rights they have are different because they were not signatories to a treaty with any federal or provincial government. That's where I'm coming from in saying that our obligation is higher, from my perspective, with respect to aboriginal people because of that history and because of the existence of those treaties, which are not the same for any other group in the country.

The Chair: Ms. Witmer and then Ms. Wynne. I believe you had a question a few minutes ago.

Mrs. Witmer: I think these amendments that are being proposed and supported by the First Nations and the aboriginal community really speak to the fact that, as a result of the approach that has been taken by the government, contrary to what had been promised, it puts

them in a position where they're not sure they can trust the government totally moving forward. The Chiefs of Ontario state that the amendments that have been proposed by the government do not reflect the necessary partnership required. I think we have to seriously consider how we have treated these individuals. In fact, they say that the development of the LHINs project has not been consistent with the spirit and letter of the health blueprint, and that's why they are insisting on an exemption or a specific clause that protects current and future health programs and services. Again, they stress the fact that they're not to be treated as stakeholders, as the government has regrettably attempted to do, but should be treated on a government-to-government basis. I think we find ourselves in a dilemma now where we are trying to afford them some protection in dealing with these amendments. I guess if the consultation had taken place prior to the drafting of the legislation, and there had been real consultation government to government, we wouldn't be facing the predicament that we have today.

The Chair: Ms. Wynne.

Ms. Wynne: I do appreciate the lofty sentiments of people who have been members of previous governments. But given that this is the first time in provincial history that there is a mandated voice for aboriginal people in a government-to-government forum over provincial health planning, I think we're on pretty safe ground in terms of the way we're moving forward. So I think we'll be sticking with our amendments.

The Chair: Any further debate?

Ms. Martel: As a member of a government that was a signatory to the statement of political relationship with aboriginal peoples, which set out a process for resource allocation, for example, in commercial fisheries, just to give one example—logging rights were others—I think there has been a clear indication previously, and a clear process previously, where First Nations were adequately consulted and involved in planning. I regret that it has not been the case with this particular piece of legislation, nor was it with Bill 210. Now we are here picking up the pieces, and we shouldn't have to be, especially in light of the statement made by the government just this summer that there was going to be a new relationship.

The Chair: Any further debate? If there is none, I will now put the question.

Ms. Martel: I would like a recorded vote.

Ayes

Arnott, Martel, Witmer.

Nays

Craitor, Fonseca, Leal, Ramal, Wynne.

The Chair: The amendment does not carry.

There is a 15a. I believe it's from you, Madam Martel.

Ms. Martel: I move that the bill be amended by adding the following section:

"Delivery of aboriginal health care

"2.2(1) Nothing contained in this act and no action taken under this act shall be interpreted to or have the effect of removing responsibility for the delivery of health services and programs that are directed primarily at First Nations peoples from the ministry and transferring it to another person or entity.

"Same

"(2) Despite subsection (1), a First Nation and a local health integration network may, with the consent of the ministry, enter into an agreement by which all or part of a health service or program that is directed primarily at First Nations peoples be administered or delivered, with respect to the First Nation entering into the agreement, by the local health integration network."

Again, that was the third of the three summary recommendations, specifically with respect to language for amendments, that were presented to the committee by the Union of Ontario Indians last week on February 7. I would encourage members of the committee to support this amendment, given what has gone on in this process to date, and given that the amendments that are coming forward from the government are not deemed to be acceptable by First Nations involved in this process.

The Chair: Any debate on the motion? If there is no debate, I will now put the question.

Ms. Martel: A recorded vote.

1750

Ayes

Arnott, Martel, Witmer.

Nays

Craitor, Fonseca, Leal, Ramal, Wynne.

The Chair: The amendment does not carry.

We go to section 3: Madam Witmer, page 16.

Mrs. Witmer: I move that section 3 of the bill be amended by adding the following subsections:

"City of Toronto

"(1.1) Despite subsection (1), the geographic area of the health integration network of Toronto Central shall consist of the city of Toronto.

"City of Toronto

"(5) The Lieutenant Governor in Council shall not make any regulation under subsection (4) that would have the effect of changing the geographic area of the local health integration network whose geographic area consists of the city of Toronto."

As you know, the city of Toronto appeared before us. They are extremely concerned about the fact that this city is going to be served by a total of five different LHINs and only one of those five, which is the Central LHIN, which contains, I think, about 1.5 million people, is going to be fully within the boundaries of the city of Toronto. In fact, if we take a look at these other LHINs, they are very far-reaching into communities that really don't have any community of interest with the city of Toronto at all.

As a result, if you take a look at some of the rural areas, they don't have the same urban health and social service issues that we see in the city of Toronto.

If we take a look at this amendment which has been put forward by the city of Toronto, it would ensure that the entire city of Toronto is served by only one LHIN, meaning that all the city-run health providers, such as the long-term-care homes in the city, would report to one LHIN. Unless this model is adopted, the city of Toronto believes that their powers as a government—and they have been given new powers by the government recently—and its abilities as a systems manager are going to be severely compromised.

They also think that what else is going to be compromised will be their access to equal services if the LHINs that are going to be governing the city of Toronto take different funding decisions for the health service providers, which well could happen. They want this amendment because they want to ensure that everyone living within the boundaries of the city of Toronto, in all parts of the city, would have equal access to the same level of service. So we put this forward on behalf of the city of Toronto.

The Chair: Any debate?

Ms. Wynne: I'm speaking both as a member of this committee and as, I think, the only Toronto member who's sitting around this table. I think this would be a very big mistake. I represent a riding that has a number of institutions to which people come from a variety of places around the province. The city of Toronto has to relate to places outside its boundaries, and this would be an attempt to build an artificial wall around the city of Toronto in terms of health planning. It would be a big mistake and I won't support it for those reasons.

Mr. Arnott: I've listened to the parliamentary assistant's explanation for her position on this amendment, but I'd like to hear a little bit more perhaps from the staff as to the rationale for dividing the city of Toronto up into five different LHINs. I was absolutely surprised when I first learned that they were going to divide up the city of Toronto into five LHINs. It seems—

Ms. Wynne: We've gone over this a number of times. What the minister did was look at referral patterns. The LHINs were devised based on those referral patterns. We can have a debate about whether they were accurate or not, but the referral patterns are not contained within the political boundary of the city of Toronto. That's why the LHINs were arranged the way they were. I don't think there's any other more complicated answer to it than that. That is the way they were established.

The Chair: Mr. Arnott, you still have the floor.

Mr. Arnott: I know we've heard that that is the rationale for the establishment of the LHINs, but there are examples all across the province where the referral patterns are not entirely respected. For example, the LHIN that my riding is included in is called Waterloo-Wellington. The fact is, the referral patterns, for example, from the Palmerston hospital, in most cases, go to Stratford, which is outside the boundaries of the LHIN. Obviously geographic boundaries were considered to be

the primary consideration in the case of the establishment of Waterloo-Wellington. I'm not criticizing that; I'm just asking, why was that not the case in Toronto?

I would suggest to you that there's perhaps another reason. I don't know if it's that the government is concerned about one LHIN representing all the city of Toronto becoming too powerful perhaps, but you obviously have to concede that if you—

Ms. Wynne: Didn't we deal with that with your government?

Mr. Arnott: If, in fact, what you're saying is true, which is of course that you need to have these LHINs to provide for local decision-making, you're going to have a hodgepodge of five different sets of rules all across the city of Toronto—a patchwork quilt of different rules, is what I'm trying to say. You're going to experience that, and I think that, over time, that is going to weaken the structure you're trying to set up, at least in terms of popular support.

I'm surprised you would reject the city of Toronto's position that they've expressed here at committee and just dismiss out of hand the city of Toronto, which represents the whole city. You just dismiss it out of hand. I'm surprised that you would say that as a Toronto member.

The Chair: Ms. Martel?

Ms. Martel: I think we heard during the course of the public hearings that some of the referral patterns don't make sense at all—people from Sarnia going to Windsor when in fact they normally go to London, so I don't want to use referral patterns as the basis for much with respect to this legislation given what we heard.

One of the concerns that particularly struck me with the city of Toronto is that they operate 10 municipal homes for the aged. You would think there's probably a common set of standards, a common principle with respect to that operation, which cannot be guaranteed when those homes fall into different LHINs. I would assume they are the only city where that has happened because I'm assuming they're the only city that is divided up into a number of different LHINs.

There are some comments about referral patterns which I don't hold much stock in given what we heard, but clearly a legitimate concern that I thought was raised from the perspective of the city funding these organizations was, what guarantee did they have about what the quality of service will be in those homes when they now belong to five different LHINs versus the situation right now where the city, because of the city boundaries, has some say over what the policies, procedures and the framework are for providing service in those homes.

The Chair: If there's no further debate, I will now put the question. Is there anyone in favour of the motion? Against? The motion does not carry.

It is 6 o'clock, and at this point the meeting comes to an end.

We thank you for your participation, and we will come back tomorrow at the same place at about the same time, 3:30. Thank you.

The committee adjourned at 1800.

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Mrs. Elizabeth Witmer (Kitchener–Waterloo PC)

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Mardi 14 février 2006

Standing committee on social policy

Local Health System
Integration Act, 2006

Comité permanent de la politique sociale

Loi de 2006 sur l'intégration
du système de santé local



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STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 14 February 2006

Mardi 14 février 2006

*The committee met at 1555 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006
LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

The Chair (Mr. Mario G. Racco (Thornhill)): Good afternoon and welcome. We will resume our clause-by-clause consideration where we left off yesterday. Before I ask the NDP to move the motion we were left at—I think it's page 17—I want to inform you that there was a motion today that extended the hearings until tomorrow. Tomorrow we will be starting at 10 a.m., until 1 p.m., so there will be that addition.

Having said that, I will go to Madam Witmer. Do you have something to add?

Mrs. Elizabeth Witmer (Kitchener-Waterloo): I just want the record to show that I think we've come in here in good faith, hoping we would have ample opportunity to debate all the amendments we have received from those who took the time to make presentations to us. Unfortunately, we are still continuing to receive some amendments from the government. So if there has been any delay in the work of this clause-by-clause committee, I think part of it is because the government has not had their amendments ready to provide us with. I would just like the record to show that, because we have been ready to go since yesterday.

The Chair: Just for the record—I appreciate your comments—both the government and the NDP, as I understand it, provided additional motions yesterday. Today, my understanding is it's the same. There are a few that both parties are going to introduce. Having said that, I thank you for your comments for the record.

I'll go back to Madam Martel. You will start on page 17, I believe.

Ms. Shelley Martel (Nickel Belt): Chair, could I just be clear, did we actually vote, before we finished last night, on the amendment with respect to the city of Toronto?

The Chair: You're referring to page 16, am I right?

Ms. Martel: Yes.

The Chair: Yes, we did, and it lost. That's why we are starting on page 17, which is your motion.

Ms. Martel: Thanks, Mr. Chair. Before I move the motion, I want to express my thanks on the record to Mr. Halporn, legislative counsel, who has been working overtime to try to prepare our amendments. He let us know late Wednesday night that he would not be able to get all the amendments ready for Thursday by the 5 o'clock deadline, which is why I asked the clerk to send a note to everybody saying that we would continue to put forward amendments as he finished them, and that's what we have tried to do. I wanted to put on the record my thanks to him for his incredible, difficult work over the past couple of days.

Let me move on to this section.

I move that section 3 of the bill be amended by adding the following subsection:

"Same

"(5) The Lieutenant Governor in Council shall make regulations prescribing conflict of interest policies and rules for the members, directors, officers and employees of local health integration networks."

Members will see that this comes under the section in the bill, page 7, that talks about the regulations the Lieutenant Governor in Council has an ability to put forward. They involve the LHINs: amalgamation, dissolving, dividing LHINs, changing the names etc.

The reason I have put into this section specifically a reference to conflict-of-interest guidelines is because in another section in the bill it talks about the minister in conjunction with an individual LHIN developing those conflict-of-interest guidelines. My suggestion is that the conflict-of-interest guidelines should be the same for all LHINs, for all members, for all employees etc. That should be done for all of the 14 at the same time and it should be done through a process of consultation, as is outlined in sections that carry on further about having to be posted on the Gazette etc.

I think if you're going to have a standard set of conflict-of-interest guidelines that apply equally to everybody, the way to do that is to have that done by the LG for all 14 rather than having the minister, in discussion with each individual LHIN, develop what may turn out to be different policies.

The Chair: Any debate on the motion?

Ms. Kathleen O. Wynne (Don Valley West): Just to say that in subsection 8(8), because the discussion in

each case will be with the minister, we believe that's adequate on the development of conflict-of-interest guidelines.

1600

The Chair: Any further debate? If there is none, I will put the question. Those in favour? Those opposed? The motion does not carry.

I will take a vote on section 3. Shall section 3 carry? Those in favour? Those against? It carries.

Section 4: There are no amendments, so we'll take a vote. Shall section 4 carry? Those in favour? Those opposed? Section 4 carries.

Section 5, a number of amendments. The first is on page 18. Mrs. Witmer, please.

Mrs. Witmer: I move that section 5 of the bill be amended by adding "to achieve the purpose of this act" after "system" in the portion before clause (a).

This is an amendment that was requested by the Council of Academic Hospitals of Ontario, plus the Ontario Hospital Association. If the people in this room were to adopt this amendment, it would enshrine the achievement of the purpose of the act, as set out in section 1, as the overarching object of the bill. The objects should be consistent with the purpose, thus providing a rationale for the objects. It also provides further standards by which the LHIN board can exercise its powers and provide a guide as to which decisions are in the best interests of the LHIN.

The Chair: Any further debate?

Ms. Wynne: We have no objection to this amendment.

The Chair: If there is none, I will put the question. Those in favour of the amendment? Those opposed? The amendment carries.

Page 19, Madam Witmer, please.

Mrs. Witmer: Clauses 5(a.1) to (a.4):

I move that section 5 of the bill be amended by adding the following clauses:

"(a.1) to optimise the health status of residents in the area of jurisdiction of the local health integration network;

"(a.2) to improve access to health care services for residents in the area of jurisdiction of the local health integration network;

"(a.3) to ensure timely access to a range of health care services prescribed by the minister for residents in the area of jurisdiction of the local health integration network;

"(a.4) to increase the quality and improve the outcomes of health services provided in the area of jurisdiction of the local health integration network."

This was an amendment requested by the GTA/905 Healthcare Alliance. As written, they believed that the objects currently are not focused on improving health care in Ontario or on improving the health status of Ontarians. These four proposed additions to the objects of the bill would establish optimising health status, improving timely access to health care services, and increasing the quality and outcomes of health services in

a LHIN. They believe that is just as important as the achievement of any efficiencies within the system.

The Chair: Any debate?

Ms. Wynne: I won't be supporting this amendment; (a.1) and (a.4) are actually not solely the purview of the LHINs, and (a.2) is covered in 5(h) already in the bill. So I won't be supporting this.

The Chair: Any further debate? If there is none, I will put the question. Those in favour of the amendment? Those opposed? The amendment does not carry.

Page 20, Mrs. Witmer, please.

Mrs. Witmer: I move that clause 5(b) of the bill be amended by adding, after "needs of the local health system," "based on the population size and population characteristics in the area of jurisdiction of the local health integration network."

Again, this was an amendment put forward by the GTA/905 Healthcare Alliance. It was really encouraging us to take a look where people live. There is currently no model for how the health service needs of a LHIN will be determined beyond consultation. If this amendment were to be adopted, it would ensure that population size and characteristics are taken into account as one of the factors during the planning stages.

The Chair: Any debate?

Ms. Wynne: I see this as a clause that would actually restrict the planning capacity of the LHIN and would preclude some of the cross-LHIN planning and communication that needs to happen. So I won't be supporting it.

The Chair: Any further debate? I will now put the question. Those in favour? Those opposed? The motion does not carry.

Page 21, Madam Martel.

Ms. Martel: I move that clause 5(c) of the bill be amended by striking out "community input and consultation" at the end and substituting "consultation with and input from, at all stages of decision-making, the community, including but not limited to, equality-seeking groups."

Over the course of the public hearings, we heard the concern from many presenters about how the community was going to be involved in the decision-making process. While this appears as an object of the LHIN, I have expanded it so that it makes it clear that input has to be sought from the community at all levels of decision-making, and that input has to be sought from the broadest possible community, particularly those who are the most vulnerable, who have the least say in the health care system and whose needs we have to look out for. I might make reference at this point to those who are consumers or survivors of mental health services, for example.

The Chair: Any debate?

Ms. Wynne: I don't disagree with Ms. Martel that we heard a lot about community engagement. We're going to be bringing amendments to section 16 that will elaborate on what we mean by community engagement.

The Chair: Any further debate? I will now put the question. Those in favour? Those opposed? It does not carry.

Page 22, Ms. Wynne.

Ms. Wynne: I move that clause 5(g) of the bill be amended by adding “including academic health science centres” after “health service providers.”

Clause 5(g) is the object that requires LHINs to develop strategies and co-operate with health service providers, including, now, academic health science centres.

The Chair: Any debate? I will now put the question. Those in favour? Those opposed? The motion carries.

Page 23, Mrs. Witmer.

Mrs. Witmer: I move that clause 5(g) of the bill be amended by adding “and to support the development and adoption of new technologies and models of care” at the end.

Again, this was requested by the Ontario Hospital Association and the Council of Academic Hospitals of Ontario. There was some concern that there was a need for this amendment to ensure the support of the academic health science centres and recognize that they are the building blocks to innovation, and also to make sure that the value of teaching and research is recognized.

We’ve just adopted the other amendment, so there is a recognition at this point. We could probably withdraw this particular amendment.

The Chair: Okay. That was easy. If that is the case, we don’t have to deal with it. If you withdraw it, then there is no motion, so page 23 is off the list.

We go to page 24, Ms. Wynne.

Ms. Wynne: I move that clause 5(h) of the bill be amended by striking out “access to health services” and substituting “patient care and access to high quality health services.”

What this does is add the concepts of patient care and quality to the object.

The Chair: Is there any debate on the motion? I will put the question. Those in favour? Those opposed? The motion carries.

Page 25, Mrs. Witmer, please.

Mrs. Witmer: I move that clauses 5(h), (i) and (j) of the bill be struck out and the following substituted:

“(h) to undertake and participate in joint strategies with the following organizations to improve access to high quality health services and to enhance continuity of health care across local health systems and across the province:

“(i) other local health integration networks,

“(ii) agencies, health care registries and other persons or organizations with a provincial mandate that relates directly to health care and that is endorsed by the ministry, including the Cardiac Care Network of Ontario;

“(h.1) to work with other local health integration networks to ensure a coordinated approach to province-wide health care issues, including but not limited to issues related to cardiac care;

“(h.2) to acknowledge and support the importance of facilities that provide education and research in health services;

“(i) to co-operate with other local health integration networks, health service providers and others to support

health care research and knowledge creation, to identify and disseminate information on best practices and to promote knowledge transfer among local health integration networks and health service providers;

“(j) to bring economic efficiencies to the delivery of health services and to promote innovation in health services and care to make the health system more effective and sustainable;”

1610

The addition of “high quality” was requested by the Ontario Hospital Association, the Council of Academic Hospitals of Ontario and the Cardiac Care Network because they wanted this to become an object of the legislation. The Cardiac Care Network wanted to ensure that the amendments here would mean there was going to be inter-LHIN coordination and provide an obligation for LHINs to work with the ministry-endorsed province-wide organizations such as the CCN. It was really focused on promoting inter-LHIN coordination. That is the reason for this amendment.

The Chair: Any debate on the motion?

Ms. Wynne: I appreciate the intent of the amendment. The LHIN objects already require them to work with provincial programs. Our problem is that focusing on cardiac care is too narrow a focus. A number of groups came to us who were interested in having their program identified, and I think that’s not the way we’re going to be able to go.

Our motion 22 already recognizes the importance of the LHINs working with education and research organizations, so we won’t be supporting the motion.

The Chair: Any further debate? I will now put the question. Those in favour of the motion? Those opposed? The motion does not carry.

Page 26, Ms. Witmer, please.

Mrs. Witmer: I move that section 5 of the bill be amended by striking out “and” at the end of clause (m) and by adding the following clauses:

“(m.1) to develop strategies and to co-operate with other local health integration networks, health service providers and others to support the training of future health care professionals and health human resources planning and education;

“(m.2) to co-operate with other local health integration networks to ensure that improvements in access, integration and the coordination of health services do not restrict or prevent an individual from making choices about his or her own health care;

“(m.3) to ensure that placement processes relating to long-term care are carried out in accordance with the standards set under subsection 5 (3); and”

This is a request again of the Ontario Hospital Association as well as the Ontario Long Term Care Association and it acknowledges the importance of developing and training health human resources and commits the LHINs to support that much-needed training. Also, it speaks to the need to state as an object of the legislation the maintenance of patient choice in accessing health care.

The addition of clause (m.3) establishes as an object of the legislation the standardization of the LTC placement process. It is hoped that that would limit confusion for both applicants and their families and allow for some stability in the placement process during the consolidation of the CCACs to match the LHIN boundaries.

The Chair: Any debate?

Ms. Wynne: Just to say that there are a number of motions for which this is an issue; that is, part of this motion is a provincial responsibility and we have to recognize that not all responsibilities, obviously, are being put into the LHINs. So (m.1) and (m.3) are still provincial responsibilities and, most appropriately, would not be in this legislation.

The Chair: Any further debate? If there is none, I will ask the question. Those in favour of the amendment? Those opposed? The amendment does not carry.

Page 27, Mrs. Witmer, please.

Mrs. Witmer: I move that section 5 of the bill be amended by adding the following subsection:

“Regulations

“(2) The minister shall set standards for placement processes relating to long-term care, including but not limited to standards for,

“(a) the determination of eligibility;

“(b) admission assessments;

“(c) waitlist management and prioritization;

“(d) the management of bed offers;

“(e) the monitoring of effectiveness of placement processes; and

“(f) measuring the accountability of networks for long-term-care placement processes.”

This actually flows out of the amendment that I had before, that 5(m.3). Again, this would give the minister the power to set the centralized standards for long-term-care placement processes, as enumerated. It would ensure a degree of stability of LTC placements during that consolidation of the CCACs to match the LHIN boundaries. It would limit confusion for the applicants and their families. It would allow for customization at the LHIN level through the local processes.

The Chair: Any debate?

Ms. Wynne: I think that this particular motion would actually be more appropriate for long-term-care legislation than for this legislation. So we won't be supporting it.

The Chair: Any other debate? If there's none, I will put the question. Those in favour of the amendment? Those opposed? It does not carry. Now we have finished the section.

Shall section 5, as amended, carry? Those in favour? Those opposed? Section 5 carried.

I will ask the Vice-Chair to please chair for a few minutes. I have to make an important call. Thank you.

The Vice-Chair (Mr. Khalil Ramal): We now move to page 28: Ms. Martel.

Ms. Martel: I move that section 6 of the bill be amended by adding the following subsection:

“No competitive bidding

“(5.1) A local health integration network shall not use competitive bidding, a managed competition or any other similar process for any purpose under this act.”

Now I'm going to make a few comments. This has come under section 6 of the act, which outlines the power of the LHINs, and that's probably the most appropriate place for it to be mentioned. That whole section lists the many things they can and can't do, and it should be appropriate in this section to make it clear that they cannot apply competitive bidding to any of the health sector that they are going to be responsible for under this bill.

A couple of things: We heard from many groups during the course of the public hearings about how chaotic and how destructive competitive bidding has been as a process in home care. Here are but a few of those concerns.

Number one: Because there were so many changes in contracts as a result of the RFP process that is inherent in competitive bidding, many clients—indeed, thousands of clients, even in the last two years alone—have experienced significant disruption in their service and significant changeover in their service providers. We need to remember that these clients have an intimate relationship with their providers. They're coming into their homes. They're doing housekeeping. In many cases, they're bathing them. These are not links and attachments that we should be having upheavals with every time there's a change in a contract, which is what has been the case with competitive bidding. So it's had a major negative impact on many thousands of clients across the province.

Secondly, major negative impacts on health care workers: Competitive bidding has resulted in a driving down of wages and salaries of workers in this sector. I remind members that this is a sector where employees are already very low-paid, especially those who don't even have the protection of a union. What has happened under competitive bidding is that the wages that were already not very good have been driven down; people have lost mileage; people have lost a benefit plan; people have lost a partial or a full pension plan; people are paid per visit now instead of by the hour.

There have been many very negative changes, and I think we heard that most clearly and most articulately from Madam Lebrun, who made the presentation in Ottawa, although I should point out that there was also a second presentation by a second PSW at the end of our hearings, a Toronto worker who was very articulate in this regard as well. These changes in home care have essentially been done on the backs of these workers who have lost wages and other benefits as a result of companies trying to drive down their costs in order to get bids.

Third, there has been a very significant shift in the sector from home care being delivered by not-for-profit organizations to for-profit. Competitive bidding has come at the expense of small, community-based, non-profit organizations that had a niche in home care and have

now lost that niche. Indeed, that was pointed out to us during the course of the public hearings in references to a 2001 report that had been done by Doran and Doran at the U of T. That report showed very clearly that before competitive bidding was imposed by the Conservatives, only 18% of the providers of home care were for-profit providers. By 2001, that had shifted to over 48% of the providers in home care being for-profit providers. In 2006, I suspect, that's well over 50% to 55%. Not only is that a very significant shift, what it means is that money that should be going into patient care, into direct delivery of home care services, is instead being diverted to the profits of those for-profit companies. Surely, the government, as it talks about its commitment to medicare and its commitment to publicly funded, publicly accessible health care, should be worried about that very significant shift to for-profit agencies and the potential for a similar shift in the broader health care sector that will be under the responsibility of the LHINs.

1620

Now, the minister said the following in his opening remarks, and I want to put this back on the record. I'm quoting from his remarks to the standing committee, January 30, 2006, when he was outlining what he alleged were myths that were being raised by a number of people who had concerns about the bill, the critics of the bill. Here's what he said: "Local health integration networks are going to extend the competitive bidding model to the entire public health care system." He went on to say, "Well, I don't want to seem repetitive, but I'm holding the bill right here ... and, as I've said, I have read it many times. Folks, it doesn't say that anywhere.... LHINs are designed to better manage and coordinate health care services in order to ensure better access to those services. That does not mean competitive bidding."

I challenge the minister, as I have challenged committee members before when we've talked about competitive bidding and when government members have said there's nothing in the bill that talks about competitive bidding. If you want to prohibit competitive bidding, then you put it in the legislation. You make sure that a process that has been so destructive in home care is not permitted to be applied to the other sectors in health that the LHINs are going to be responsible for. We know what those sectors are. If you mean what you say, which is competitive bidding is not in the bill, it's not going to be used, and if the minister means what he says, that is, that competitive bidding does not apply, then we put it in the bill and we make it clear that LHINs are prohibited from using competitive bidding in any shape or form. That's why it appears in the section under the powers of the bill, and I think it's time to do what is right and make sure we cut off at the knees the same kind of destruction and chaos that we saw through home care.

It is very regrettable that through the process that the minister instituted with Elinor Caplan the end result was not that competitive bidding would now be banned in home care too. It should have been. There is more than enough evidence to show why it doesn't work, how

destructive it has been and how much money is being diverted from patient care into the profits of for-profit companies. The government didn't do this with respect to home care, and it should have. You now have an opportunity to make sure that this is not extended. Frankly, if the minister means what he says about the Canada Health Act and about Bill 8 and about ensuring the system is publicly funded and publicly accessible, then the committee members will vote today in favour of my amendment to prohibit any further extension of competitive bidding into any other health care sector.

The Vice-Chair: Is there any further debate?

Ms. Wynne: I just want to begin by saying that I appreciate the number of times this issue came forward, and I certainly appreciate the impassioned presentation by Ms. Martel. As the minister has said, there is no expansion in this bill of the competitive bidding model that is in place right now in the province, the one that the community care access centres are engaged in. This bill doesn't envisage an expansion of that.

The reason that I won't be supporting this amendment is that what the minister does envisage is that there will need to be a healthy competitive process among the non-profit providers of health care. If you look at the provision of services around our wait-time strategy, there may very well need to be a competition among the not-for-profit providers of those kinds of services. What we don't want to do is put into the bill something that's going to squelch that kind of process. I won't be supporting the amendment, although I did hear the concern from many of the presenters. If I believed that what this bill was going to do was expand that process, then I wouldn't be in favour, but I don't believe that's what the bill envisages. I do believe there needs to be a healthy dynamic among the not-for-profit providers, so I won't be supporting the amendment.

Ms. Martel: In response, let me make it clear that the bill is silent on how the LHINs are going to acquire, obtain, receive or provide services in the sector. That's the whole point. The bill says nothing about how services that LHINs are responsible for are going to be acquired. What I want to do, and what I think this committee should do, is shut the door in the face of the process being used as one of competitive bidding or managed competition. That's the dilemma. It's true that the bill says nothing about competitive bidding being the model the LHINs are going to use; it also doesn't prohibit them from doing that. So instead of remaining silent on this issue and waiting to see what's going to happen, we should be moving now to shut that door, to slam that door shut, especially given everything we've seen in community care access centres and in home care, and especially given what we heard from front-line providers during the course of the public hearings.

Your minister says that there's nothing in this bill that's going to result in more privatization. I have to tell you that that's exactly what competitive bidding did in the home care sector. The study that was done by U of T, even in 2001, made that clear. So if you don't have a

prohibition in this legislation that stops LHINs from acquiring other services in the same way, you're darn right you're going to have more privatization, absolutely, because that is what the result has been in home care alone. You don't want to apply that to other sectors, because you don't want to see that chaos for patients, that disruption to home care workers and that shift to the for-profit sector happening in other sectors of health care as well.

The problem is, the bill is silent on how LHINs are going to obtain services. I am not going to take the minister at his word when he says, "Well, it's not in the bill, so it's not going to happen." The way you guarantee it's not going to happen is to have it clearly articulated and clearly stated in the bill, very directly, under the power of the LHINs, that they will not be allowed to use this model to acquire or obtain those services that they are given funding for to purchase or provide. That's the way we shut this down. The way to make it very clear is to have it in the legislation. If the minister means what he said at the committee, that "I don't see competitive bidding anywhere here," then the minister should have it explicitly in the bill in this section. I encourage the government members to vote in favour of this amendment and ensure that there will be a very clear prohibition for the use of this model in other health care sectors that LHINs will be responsible for.

Ms. Wynne: Actually, I think I've said what I need to say. If clinical services are delivered by publicly funded institutions, not-for-profits, and if there is the need on a particular issue—provision of cardiac services or joint replacement or MRIs—to look at our wait time issues and the need for a dynamic among those organizations to determine where the capacity is, then the process of competitive bidding could be used among those public providers. We're not going to close the door on that process, and so we won't be supporting this very general amendment.

The Vice-Chair: Ms. Martel.

Ms. Martel: If I might, just to follow up, the bill doesn't even limit it to the examples that you're outlining, Ms. Wynne. You've given us some examples of where competitive bidding might be required, and you're not going to vote for the amendment because in those cases competitive bidding might be necessary. I disagree that competitive bidding should be the way. Even if it was the case that you were only referring to those sections, that's not explicit in the bill either. The bill is entirely wide open to say that this is not prohibited, not just in the cases you've outlined but not in any case. There is no prohibition whatsoever, and there is no reference to the use of competitive bidding as you've described it in those circumstances that you've just given to the committee. There's nothing in the bill that reflects that.

Ms. Wynne: I will say finally, and I won't engage in further debate after this, that I think there is a need to look at our track record in terms of how we have done since we've been elected in terms of protecting public

health care: passing Bill 8 to ban two-tier medicine; repatriating the MRI clinics from private clinics into the public sector. We told the Copeman clinics that the private clinics are not acceptable. So I think that we have demonstrated our commitment to public health care, and that is our track record. I'm going to stop at that.

The Vice-Chair: That's it?

Ms. Wynne: Yes. Actually, I'd like to call for a five-minute recess before the vote, but I don't know if Ms. Martel—

The Vice-Chair: We'll listen to Ms. Martel first.

Ms. Martel: Just in response, and then I'll finish up as well: Look at the track record of this government with respect to competitive bidding. The Conservatives brought in competitive bidding. Your government had an opportunity to end it. You had Elinor Caplan do a report on competitive bidding, but she wasn't even given an option to look at ending competitive bidding. Her option was to try and streamline it or fix it or tinker with it to make it better.

We heard presentation after presentation from people who are living with the experience of competitive bidding in home care now. You should have shut that down when you were elected. You should shut it down now, and you're not going to do that. What we heard during the course of the public hearings should convince anybody, but particularly the government members, that competitive bidding is wrong. We should shut it down in home care, and we should shut it down now.

On the track record that you have, the one you forgot to mention was the track record of continuing to support competitive bidding in home care. It has been a disaster. You should have ended it, and you should end it now.

The Vice-Chair: Ms. Wynne has asked for a five-minute recess. A motion?

Ms. Wynne: Yes. I'd like to request a five-minute recess. I so move.

The Vice-Chair: Does anybody object to that? No. Then we are recessing.

The committee recessed from 1632 to 1639.

The Chair: Are we ready for the vote?

Ms. Martel: I'd like a recorded vote.

The Chair: The motion on page 28 has been moved by Madam Martel. I will put the question for a vote.

Ayes

Craitor, Martel.

Nays

Fonseca, Leal, Ramal, Wynne.

The Chair: The motion does not carry.

Shall section 6 carry? Those in favour? Those opposed? Section 6 carries.

We'll go to sections 6.1 and 6.2.

Mrs. Witmer: I move that the bill be amended by adding the following sections:

“Toronto collaborative board

“6.1(1) A collaborative board is established with the number of members to be set by the minister, with an equal number of members representing all local health integration networks whose geographic areas cover any part of the city of Toronto and members representing the city of Toronto.

“Appointment of members

“(2) All local health integration networks whose geographic areas cover any part of the city of Toronto shall jointly appoint the members of the board who represent those networks.

“Same

“(3) The city of Toronto shall appoint the members of the board who represent the city of Toronto.

“Consultation

“(4) In exercising any of its powers with respect to services operated by or with funding from the city of Toronto, a local health integration network whose geographic areas cover any part of the city of Toronto shall consult with the board.

“Partnerships

“6.2 In exercising any of its powers, a local health integration network shall establish and maintain partnerships with other local health integration networks and with health service providers that do not receive funding under subsection 19(1) as the network considers appropriate.”

As you know, I’m putting forward this motion because the previous motion that I had put forward to create one LHIN for all of Toronto was not accepted. There’s a huge concern on the part of the city of Toronto because there are five different LHINs. There is a concern that the levels of health, provision of services and funding may be quite different. They want one board created, which would ensure that all LHINs that share responsibility for parts of the city of Toronto would work together in collaboration. It would also mean that the board must be consulted prior to any of the LHINs making a decision affecting a part of the city of Toronto. What they would hope to achieve is some maintenance of standards across the entire city as far as the service delivery is concerned.

The Chair: Any debate on the motion? Ms. Wynne.

Ms. Wynne: Just to say—and I spoke to this issue previously—that there are other places in the province that have issues similar to the city of Toronto’s and that there are health providers other than just the city’s that deliver services across LHINs. There is already provision in the bill that requires that there be inter-LHIN communication, so I won’t be supporting this.

The Chair: Any further debate?

Mrs. Witmer: Recorded vote.

Ayes

Martel, Witmer.

Nays

Craitor, Fonseca, Leal, Ramal, Wynne.

The Chair: The amendment does not carry. Therefore, I will take a vote on the section.

Interjection.

The Chair: It’s all new. Okay.

Section 7, page 30. Ms. Martel, please.

Ms. Martel: I move that subsection 7(1) of the bill be amended by striking out “appointed by the Lieutenant Governor in Council.”

This is the section of the bill that talks about the members of the LHIN boards being appointed by the Lieutenant Governor in Council or essentially appointed by the government. I am suggesting that “appointed by the Lieutenant Governor in Council” be taken out because, in amendments that will follow, I will propose a system for election of the members of the board versus appointment by the government.

We had a wide range of views about this matter, a number of people who came forward to say that if the LHIN boards of directors were truly accountable, then they would be given their place through some form of an election instead of an appointment by the government. The appointment by the government makes them accountable to the government and not to the communities they are purported to serve. The change in section 7 that’s being proposed here would be followed by other amendments that would require an election of the LHIN board of directors.

Ms. Wynne: I’m going to continue to support the public appointment process for the LHIN boards. The government continues to be ultimately responsible, and during the hearings I think we talked a lot about the need for specific representation and expertise on these boards. So I won’t be supporting this amendment.

The Chair: Any further debate? If there is none, I will put the question.

Ms. Martel: Recorded vote.

Ayes

Martel.

Nays

Craitor, Fonseca, Leal, Ramal, Witmer, Wynne.

The Chair: The amendment does not carry. Mrs. Witmer, page 31.

Mrs. Witmer: I move that section 7 of the bill be amended by adding the following subsections:

“Composition of members

“(1.1) The members of the board of directors of every local health integration network shall,

“(a) be residents of the communities located in the geographic area of the network and be representative of those communities;

“(b) be appointed on the basis of their skills and knowledge to further the objects of the network;

“(c) reflect the diversity of the population of the geographic area of the network, based on language, culture,

gender and other grounds that the Lieutenant Governor in Council determines;

“(d) include at least one person with a paediatric background or knowledge; and

“(e) include at least one person who is an elected representative of a municipality located in the geographic area of the network.

“Nomination process

“(1.2) Every local health integration network shall provide to the minister the names of at least one and at most three nominees for appointment to each position on the board of directors of the network and the minister shall forward the names to the Lieutenant Governor in Council.

“Same

“(1.3) In making the nominations, the network shall follow a process that is open, public and transparent and that complies with the following requirements:

“1. The communities located in the geographic area of the network shall have the opportunity to apply for nomination or to put forward names of others for nomination.

“2. The network shall publicly advertise the nomination process, including in local media, before making the nominations.

“3. The criteria that the network proposes to use in selecting nominees shall be included in the advertising mentioned in paragraph 3.

“4. The network shall ensure that there is a written description of the nomination process that is available to the public before the network begins to follow it and that the description is available on request by the minister or any member of the public.

“Factors to consider

“(1.4) In making the nominations, the network shall consider,

“(a) the qualifications, skills and experience of each nominee that are advantageous to the governance of the network; and

“(b) the degree of local representation on the board of directors and the need for knowledge and experience of the communities located in the geographic area of the network, including an understanding of local health issues, needs and priorities.”

There was a lot of concern about the way in which people are appointed. Some people wanted them to be elected to the network. We heard from the Ontario Hospital Association, Sick Kids, Yee Hong, the GTA/905 Healthcare Alliance, the Association of Municipalities of Ontario, and many of the individual representations that were made all spoke to this issue. What we're trying to do here is establish a process for the selection of board members in order to ensure they're representative of their community, that they do reflect the linguistic, geographic, cultural and gender makeup of the community. It's believed that if they do, they're going to make more appropriate decisions on behalf of their community. Also, people need to be appointed based on their skills and knowledge of health care.

What we have been forgetting in health care recently, to a large degree, is that all our wait times are focused on adults. We're really not paying a lot of attention to paediatric care. Hence the inclusion of that particular recommendation: that at least one person on the board have a background in paediatric care so that we don't neglect our children.

Municipalities are important players and there is a need for them to be represented as well.

This speaks to the selection criteria and a process for appointment. These amendments would ensure that the local community is well represented, that people have skills, expertise and experience, and that the call for nominees would precede the nomination of candidates for the appointment to the boards.

Ms. Wynne: The public appointments process already has pretty stringent guidelines in place. We're going to support that process.

The other thing is that not all the criteria here would be appropriate for every LHIN with respect to the community that they're meant to serve. Because, as Mrs. Witmer has acknowledged, the need for experience and appropriate skill is what we're looking for, we're going to support the public appointment process that's already in place. I won't be supporting this amendment.

The Chair: Any further debate? If there's none, I will put the question. Those in favour? Those opposed? It does not carry.

Ms. Martel, page 32, please.

Ms. Martel: I move that section 7 of the bill be amended by adding the following subsection:

“Election and term of members

“(1.1) The members of a local health integration network referred to in subsection (1) shall be elected by residents of the network's geographic area in accordance with the regulations and shall hold office for the term specified in the regulations.”

As I said earlier, I am quite confident that, under an election process, people with the qualifications, the expertise and the experience needed to make the kinds of decisions that LHIN boards of directors will make would rise to the surface. I am absolutely confident about that and do not see the need to have it done by an appointment in order to guarantee that. I'm also quite confident, since I see any number of people who make application to sit on boards in the health sector, that many people would come forward if the opportunity were granted to them to actually run.

If the LHIN boards of directors are going to truly be accountable to the community and not to the minister who appoints them, the way that we guarantee that is to actually have them elected by the those who live in the area that they are supposed to serve with respect to the LHIN boundaries.

The amendment here would make it very clear that there would be a process for an election that would be developed by the Lieutenant Governor that would apply to all LHINs, to make it very clear that boards of directors will be accountable back to the community,

because they will be elected by the community they are supposed to serve.

1650

The Chair: Any further debate?

Ms. Wynne: I'd just like to make the point, and I made it a number of times during the hearings, that in putting this legislation forward, we are trying to learn from the other jurisdictions in the country that have moved in this direction. The experience of other provinces has been that having elected boards has not worked. There are provinces now that are moving to appointed boards because the people whom they need to serve on these boards in this important capacity have not been stepping forward. So that's why we're putting this process in place.

Ms. Martel: Just a short point that I want to make. I find the contradiction between what the government is prepared to do with the CCACs and what the government is not prepared to do with the LHIN boards of directors very curious. It was a former Conservative government that essentially took over the CCACs, that got rid of a requirement for those folks to come from the community, for the chair and the vice-chair to be elected by other CCAC members, got rid of the provision that would have allowed CCAC boards to actually hire their own executive directors, and the government took all that on through an appointment process. Now, in this legislation, we have the situation where the government is saying, "That needs to change, and we need to go back to a situation where, under the Corporations Act, people can buy a membership and they can come to a CCAC meeting and they can elect members to sit on the CCAC board, and those members, amongst themselves, will be allowed to elect a chair and vice-chair and that board will be allowed to hire its own CEO." The government is prepared to do that with respect to the CCAC boards but not with the LHIN boards. I find that contradiction very interesting, and I don't understand it.

The Chair: Is there any further debate? If there is none, I will now put the question. Those in favour?

Ms. Martel: Recorded vote.

Ayes

Martel.

Nays

Craitor, Fonseca, Leal, Ramal, Witmer, Wynne.

The Chair: The motion does not carry.

Ms. Martel, page 33.

Ms. Martel: I move that subsections 7(2), (3) and (4) of the bill be struck out.

If there were an election process, these sections in the bill would not apply. However, the vote has been against, so I will assume that the vote is going to be against in this amendment too.

The Chair: Nonetheless, I will ask the question. Is there any—Mr. Leal, please.

Mr. Jeff Leal (Peterborough): I just have a question. If legislative counsel could find out for me—

The Chair: Yes.

Mr. Leal: Between 1990 and 1995, were there direct elections to the district health councils in Ontario?

Ms. Martel: Did they spend any money?

Mr. Leal: I want to get an answer to that.

The Chair: Do we have an answer for that?

Mr. Michael Wood: I can't give you an answer immediately on that.

Mr. Leal: You'll find that out for me and respond. Thank you, sir.

Mr. Wood: Maybe ministry counsel could help.

The Chair: Would staff of the ministry have an answer to the question?

Mr. Robert Maisey: Yes. It's Robert Maisey, legal counsel with the Ministry of Health and Long-Term Care. No, there were no direct elections. The district health council members are appointed by cabinet.

Ms. Martel: I have a question. Did the district health councils have any money to spend to purchase health care services in the way the LHINs are going to?

Interjection.

The Chair: Please. There is a question on the floor.

Mr. Maisey: No, they did not.

Ms. Martel: No, they did not. But the CCAC boards of directors have the authority to spend money, both under the previous legislation and the changes here.

The Chair: Let me see—

Mr. Leal: Do I get my chance here, Mr. Chair?

The Chair: I would prefer—I am as flexible as you want me to be. There is a motion, and that's what we should be addressing. Okay? Therefore, if you will allow me to do my job, I would prefer to concentrate on the motion in front of us now.

Mr. Leal: Oh, I'd love to engage in this debate.

The Chair: Are you okay, or do you still have a question?

Ms. Martel: So would I.

Mr. Leal: So would I.

Interjections.

The Chair: It is Valentine's Day. Can somebody bring chocolate, please?

Interjections.

The Chair: Elizabeth, help me out.

Interjections.

The Chair: As I said a few minutes ago, I don't believe that we are dealing with the amendment which is in front of us. I would appreciate your assistance. I would remind all of you that it's Valentine's Day. I have a problem at home already because I'm not at home, so don't give me more, please. The wife, and properly so, wants to go out tonight, and I can't.

Mr. Leal: I apologize, Mr. Chair.

Mrs. Witmer: So where are we now?

The Chair: We are on page 33. Are we ready to vote?

Ms. Wynne: We're ready to vote.

The Chair: I'll be happy to take a vote, then.

Those in favour of the amendment? Those opposed? The amendment does not carry.

None of the amendments to section 7 carried. Therefore, I'm going to take a vote on section 7. Shall section 7 carry?

Ms. Martel: Can I have a recorded vote?

Ayes

Craitor, Fonseca, Leal, Ramal, Wynne.

Nays

Martel, Witmer.

The Chair: Section 7 carries.

Madam Witmer, page 34, please.

Mrs. Witmer: I move that section 8 of the bill be amended by adding the following subsections:

"Community advisory committee

"(2.1) Despite subsection (2), a board of directors of a local health integration network shall establish a committee to advise the board on exercising any of the networks' powers.

"Same

"(2.2) The committee shall be composed of representatives of the community of persons and entities of the local health system."

Again, this is on behalf of the city of Toronto. They just are concerned that there's no requirement for a LHIN to somehow engage the local community. I think reference was made to the fact that the minister likes to say that community members can pick up the phone and speak to board members, but that's pretty unrealistic. So they're looking for a formal process to be established to ensure that LHINs hear directly from the community, and this community advisory board would be one way that LHINs could hear from and respond to local needs.

The Chair: Any debate on the motion?

Ms. Wynne: Just that the LHIN will be able to establish committees, including any advisory committees that it chooses. I just think that this motion is not necessary.

The Chair: Any further debate? If there's none, I will ask for the vote. Those in favour? Those opposed? The amendment does not carry.

Madam Witmer, please.

Mrs. Witmer: I move that subsection 8(8) of the bill be amended by adding, after "in consultation with the minister," "and in accordance with the regulations."

This amendment has been requested by the Ontario Long Term Care Association. As written, the legislation calls for each LHIN to make its own conflict-of-interest rules in consultation with the minister. This amendment would require the conflict-of-interest rules to be made in consultation with the minister and also in accordance with the regulations; the minister will be given the power to make regulations regarding conflict-of-interest rules. This is necessary to enhance the transparency and ensure

a consistent approach to governance of the LHINs across the province. Conflict-of-interest rules, then, would be the same for all the LHIN boards across the province. This amendment and the next one would make it a reality.

The Chair: Is there any debate on the amendment? No debate? Then I will put the question.

Those in favour of the amendment? Those opposed? It does not carry.

Ms. Martel, page 36, please.

Ms. Martel: I move that subsection 8(8) of the bill be struck out.

This is a reference to a previous amendment that would have had the Lieutenant Governor in Council develop the conflict-of-interest guidelines so that they were the same across all LHINs, versus the current process, which will now be undertaken, where each LHIN has the opportunity to develop those with the minister, which I suspect will lead to different guidelines across different LHINs. The reference was to a previous section, and it was already voted down. So this is either out of order or I will withdraw it now, because the other amendment that it was related to has been voted down. I'd like to withdraw it.

The Chair: Is there any debate on that?

Ms. Wynne: It's withdrawn.

The Chair: Page 37, Mrs. Witmer, please.

Mrs. Witmer: I move that section 8 of the bill be amended by adding the following subsection:

"Regulations re conflict of interest

"(9) The Lieutenant Governor in Council may make regulations respecting conflict-of-interest policies for the purposes of subsection (8)."

Again, a concern on the part of the Ontario Long Term Care Association. This would give the Lieutenant Governor in Council the power to create rules around conflict of interest and would enhance transparency and ensure a consistent approach to governance of the LHINs across the province.

The Chair: Any debate? If there's none, I will put the question. Those in favour of the amendment? Those opposed? The amendment does not carry.

There is no amendment that has carried, so I'll take a vote. Shall section 8 carry? Those in favour? Those opposed? Section 8 carries.

The next is section 9. Ms. Martel, page 38, a replacement.

1700

Ms. Martel: I move that subsections 9(3) and (4) of the bill be struck out and the following substituted:

"Notice

"(3) A local health integration network shall give reasonable notice to the public of the meetings of its board of directors and its committees.

"Public meetings

"(4) All meetings of the board of directors of a local health integration network and its committees shall be open to the public.

"Exceptions

“(5) Despite subsection (4), a local health integration network may exclude the public from any part of a meeting if,

“(a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;

“(b) matters of public security will be discussed;

“(c) the security of the members or property of the network will be discussed;

“(d) personal health information, as defined in section 4 of the Personal Health Information Protection Act, 2004, will be discussed;

“(e) a person involved in a civil or criminal proceeding may be prejudiced;

“(f) the safety of a person may be jeopardized;

“(g) personnel matters involving an identifiable individual, including an employee of the network, will be discussed;

“(h) negotiations or anticipated negotiations between the network and a person, bargaining agent or party to a proceeding or an anticipated proceeding relating to labour relations or a person’s employment by the network will be discussed;

“(i) litigation or contemplated litigation affecting the network will be discussed, or any legal advice provided to the network will be discussed, or any other matter subject to solicitor-client privilege will be discussed;

“(j) matters prescribed for the purposes of this clause will be discussed; or

“(k) the network will deliberate whether to exclude the public from a meeting, and the deliberation will consider whether one or more of clauses (a) through (j) are applicable to the meeting or part of the meeting.

“Motion stating reasons

“(6) A local health integration network shall not exclude the public from a meeting before a vote is held on a motion to exclude the public, which motion must clearly state the nature of the matter to be considered at the closed meeting and the general reasons why the public is being excluded.

“Taking of vote

“(7) The meeting shall not be closed to the public during the taking of the vote on the motion under subsection (6).”

The overwhelming provisions that are here—there’s one small change—come from Caroline Di Cocco’s private member’s Bill 123, Transparency in Public Matters Act, 2005. Some members of this committee—Mr. Craiton and I—were involved in the public hearings around that bill and there was much discussion among the committee members about how and when meetings should be open and those restrictions with respect to closed meetings. Almost all of the provisions here, with the exception of a small piece, relate directly back to that bill. There was, as far as I remember, pretty well unanimous agreement on the bill after the public hearings.

The Chair: Any debate?

Mr. Leal: I thank Ms. Martel for bringing this forward. I think it’s a very worthy amendment. It’s something I would encourage my government colleagues to support. I come from a municipal background and it really reflects the provisions often reflected in the Municipal Act between when you hold open meetings and meetings in camera, in caucus. This is an important amendment and I stress that my colleagues on the government side should support it.

The Chair: Mr. Craiton, you also wanted to speak on this?

Mr. Kim Craiton (Niagara Falls): I, too, congratulate Shelley. Something I personally believe in is openness and transparency. I did it on city council and make every effort up here. I love the wording. I’d like to see it applied to a lot more boards and agencies as well. I’m certainly going to support this and I’m confident that everyone will support this, so congratulations.

The Chair: Any further debate?

Ms. Martel: I’m not used to getting support. Maybe I should withdraw it.

Interjections.

The Chair: I was encouraging Ms. Witmer to say something, too. Okay, it’s still on the floor, I understand. If there is no more debate, I’m ready to ask the question. Those in favour? All are supporting it, so it carries.

The next one is for you, Ms. Witmer.

Mrs. Witmer: We can withdraw this one because we’ve just passed the NDP amendment.

The Chair: Thank you. Shall section 9, as amended, carry? Those in favour? Those opposed? Everybody is in favour. It carries.

Shall section 10 carry? There are no amendments here. Those in favour? Opposed? Section 10 carries.

Shall section 11 carry?

Interjection.

The Chair: There are no amendments.

The Clerk of the Committee (Ms. Anne Stokes): Section 11.1 is a new section.

The Chair: It’s a new section, which is yours, so we’re dealing with section 11.

Shall section 11 carry? Those opposed? Carried.

Section 11.1 is a new section. Madam Martel, page 40.

Ms. Martel: I move that the bill be amended by adding the following section:

“Conflict of interest

“11.1 Every member, director, officer and employee of a local health integration network shall comply with any conflict of interest policies and rules prescribed by the Lieutenant Governor in Council under subsection 3(5).”

I moved an amendment previously to have the LG do this so that the conflict-of-interest guidelines were standard.

The Chair: Debate? If not, I’ll put the question. Those in favour? Those opposed? It does not carry.

We’ll go the next one, section 12. Ms. Wynne, page 41 is for you.

Ms. Wynne: I move that section 12 of the bill be struck out and the following substituted:

“Audit

“12(1) The board of directors of a local health integration network shall appoint an auditor licensed under the Public Accounting Act, 2004 to audit the accounts and financial transactions of the network annually.

“Other audits

“(2) In addition to the requirement for an annual audit,

“(a) the minister may, at any time, direct that one or more auditors licensed under the Public Accounting Act, 2004 audit the accounts and financial transactions of a local health integration network; and

“(b) the Auditor General may, at any time, audit any aspect of the operations of a local health integration network.”

It is intended that LHINs would be required to undergo an annual audit by a licensed auditor and the office of the Auditor General would retain the authority to conduct audits when necessary. These were suggestions from the Auditor General.

The Chair: Any debate on this motion? No. Therefore, I put the question. Those in favour? Those opposed? Carried.

Shall section 12, as amended, carry? Those in favour? Those opposed? Carried.

Section 13, Ms. Witmer, page 42.

Mrs. Witmer: I move that section 13 of the bill be amended by adding the following subsection:

“Same

“(1.1) The annual report shall include data relating specifically to aboriginal health issues addressed by the local health integration network.”

We had a lot of discussion yesterday. The aboriginal community obviously had some concerns about the process in developing Bill 36 and the fact that they felt they were more than stakeholders. There should have been government consultation.

This one would require LHINs to keep and report on data with respect to Aboriginals so that we can be sure they will not be forgotten as the LHINs set out to reorganize the delivery of health services in the province.

The Chair: Is there any debate?

Ms. Wynne: Could I just ask Ms. Witmer: Is the wording the same as what we've got in the original amendment or was there a change? I was confused. I'm sorry, I wasn't listening closely enough.

Mrs. Witmer: Do you mean what we got from the Aboriginal community?

Ms. Wynne: No. We got a motion yesterday—

Mrs. Witmer: Oh yes, it's the same one that you have. There shouldn't be any change.

Ms. Wynne: Okay. I had understood that there might have been a change.

Mrs. Witmer: I haven't seen a change.

The Chair: Should we see the motion, or is there a question?

1710

Mr. Wood: I wonder if I could speak to this, please? On looking at the original motion tabled by Ms. Witmer, I realized that it might be more appropriate to relocate the wording in the existing subsection 13(3), which deals with contents of annual report, rather than having two subsections dealing with contents of annual report. I wrote a motion by hand to accomplish that, to preserve the existing wording of subsection 13(3) and to add to it the wording that was in Ms. Witmer's motion. So there's no difference in substance between the motion that I wrote out by hand and what was originally—

Mrs. Witmer: Let me withdraw that one I've just read, and I will move this one.

I move that subsection 13(3) of the bill be struck out and the following substituted:

“Contents

“(3) The annual report shall include,

“(a) audited financial statements for the fiscal year of the local health integration network to which the report relates; and

“(b) data relating specifically to Aboriginal health issues addressed by the local health integration network.”

The Chair: Can we have this copied?

Ms. Wynne: I thought that's what it was.

The Chair: Would that be fine, or do we need it for everyone, Madam Clerk?

Interjection.

The Chair: If you want a copy, we have to have a break, though. We have to wait. Without the clerk, we cannot proceed.

Ms. Wynne: We can't go on to the next one? Okay.

Mrs. Witmer: Why can we not?

The Chair: It's a matter of law, I'm told.

Ms. Wynne: Shelley can't even start reading?

The Chair: She's out, so we can't. I guess we can talk about other topics if you want.

Interjection.

The Chair: She's back, so we can continue. Not only must the clerk be in attendance, but also the motion should be in front of your eyes.

Ms. Wynne: The clerk and the motion should be in front of us.

The Chair: Well, no, the motion in front of your eyes; the clerk in the room.

Ms. Martel: Sorry, just to be clear, the motion that we had that was numbered 42 has been withdrawn and will be replaced by the one we're waiting for?

The Chair: Yes, we'll be replacing 42 then. Are you ready?

The Clerk of the Committee: Yes.

The Chair: The motion is in front of us. Therefore, is there any debate on the motion?

Ms. Wynne needs a few minutes to read. That's fine.

Ms. Wynne: Actually no, I'm fine.

The Chair: I'm asking if somebody is ready to ask questions, otherwise take the time.

Ms. Wynne: I'm fine. I'll be supporting this motion.

The Chair: Any further debate? If there's none, I will put the question. Those in favour? Everybody is in favour, so no opposed. The motion carries.

That is the new page 42, on section 13.

Shall section 13, as amended, carry? Those in favour? Those opposed? The section carries.

Section 14, page 43, Madam Martel.

Ms. Martel: I move that section 14 of the bill be struck out and the following substituted:

"Provincial strategic plan

"14(1) the minister shall, after holding public consultations as described in subsection (3), develop a provincial strategic plan for the health system that includes,

"(a) a vision, priorities and strategic directions for the health system consistent with the purposes of this act; and

"(b) human resource adjustment planning, including projections of health human resource need and specific measures to address anticipated shortages of health care practitioners.

"Same

"(2) The minister shall make copies of the provincial strategic plan available to the public at the offices of the ministry and shall publish it on the ministry's website.

"Public consultation

"(3) The public consultations referred to in subsection (1) shall be held,

"(a) with regard to the appropriate funding of local health integration networks;

"(b) with regard to any other matter that, in the minister's opinion, is relevant to the development of the provincial strategic plan for the health system; and

"(c) in accordance with any requirements that are prescribed."

We heard during the course of the public hearings, and we know from the bill, that the LHINs will develop their local plans based on the provincial strategic plan. The problem was that during the course of the hearings we didn't get very much information about the provincial strategic plan: how it is being developed, who is involved in that process and what will happen once it's developed. It seems to be at this point being done behind closed doors in a manner that it is not accessible to the public.

So the amendment makes changes that would require the minister to actually have some public consultations on the provincial strategic plan; that those public consultations shall certainly include funding to LHINs and other matters that the minister considers appropriate, but that that plan should also take into account human resources in the health care sector; and that the result of all that work and the actual provincial strategic plan that results should be made available to the public at large in the venues that are outlined in that amendment.

That was presented by both ONA and OPSEU.

The Chair: Thank you. Any debate?

1720

Ms. Wynne: There was comment about the provincial strategic plan, and I know there is a conversation about

what the process will be to establish that within the ministry and within the minister's office.

The concern is that setting up the consultation process in the legislation at this point could reduce flexibility in terms of finding best practices through consultation for the provincial plan in an ongoing way. So I won't be supporting this amendment.

The Chair: Any further debate? If there is none, I will put the questions. Those in favour? Those opposed? It does not carry.

Madam Witmer, page 44.

Mrs. Witmer: I move that section 14 of the bill be amended by adding "including cardiac care" after "directions for the health system."

Again, there is a concern that this amendment would require the minister to include a province-wide cardiac care plan as part of the overall provincial strategy for health care, really encouraging the minister to engage province-wide organizations, not just the CCN, in developing the provincial strategic plan.

The Chair: Any debate?

Ms. Wynne: Mr. Chair, we're going to be bringing an amendment that will require the minister to consult with province-wide planning organizations. So I won't be supporting this, as I think this is too narrow because it restricts it to CCN.

The Chair: Any further debate? Then I will follow up with the question. Anyone in favour? Anyone opposed? The motion does not carry.

I go to 44a. Ms. Witmer, please.

Mrs. Witmer: I move that section 14 of the bill be amended by adding the following subsection:

"Health services

"(1.1) The provincial strategic plan shall include, as priorities for the health system, health services, including addiction services, for the physical and mental health of patients and the obligation that the ministry and the local health integration networks are jointly responsible for ensuring that those services are available."

This amendment has been requested by the Canadian Mental Health Association, the Centre for Addiction and Mental Health, and the Ontario Federation of Community Mental Health and Addiction Programs.

I would like to stress that it is absolutely essential that the provincial strategic plan include provisions on mental health and addiction services to ensure that they are included at all times. Given the March 2005 CAMH study showing that mental health and addiction is a particularly vulnerable service sector, this statement confirming their importance ought to be included in this legislation. I just want to read from their presentation a part of their response to Bill 36. They say on page 2:

"A recent review by Ontario health system researchers found that as decisions about funding are devolved from a central governing structure to regional decision-making bodies"—which are the LHINs—"there was greater likelihood of mental health and addictions funding being lost"—it's very frightening—"due to a predominant focus on physical health needs."

So wherever we have the opportunity—and I know yesterday my amendment to better define health and include mental and physical health was rejected—the importance of mental health and addiction services must be explicitly recognized somewhere in the legislation, as these services are essential for the health of Ontarians. However, they just are often forgotten.

The Chair: Thank you. Any further debate?

Ms. Wynne: The fact that we have for the first time in a decade, in 11 or 12 years, put money into mental health really speaks to our commitment to mental health. I think we had the conversation yesterday about using a broad definition of health, so I won't be supporting this amendment.

The other thing is that including addiction services really narrows the focus more than we would want to do.

The Chair: Mrs. Witmer, please.

Mrs. Witmer: Just for the record, I think it's absolutely essential that we correct the record. Our government did undertake a huge review of mental health services. In fact, we actually had the opportunity to receive an award for our contribution, an international award, based on the work that we did in mental health, so there has been work ongoing. Regrettably, I don't think that ministries of health and governments always put as much focus and attention on this issue. This is just a reminder that we've got to have it there somewhere.

The Chair: Thank you. Any further debate? If there is none, I will put the question. Those in favour? Those opposed? It does not carry. Thank you.

The next page is 45. Madam Witmer?

Mrs. Witmer: I move that section 14 of the bill be amended by adding the following subsections:

“Long-term care

“(2) The provincial strategic plan,

“(a) shall provide that the minister is accountable for the delivery of core long-term-care programs;

“(b) shall ensure that the centralized means by which concerns related to long-term care may be brought to the attention of the ministry is continued and that each local health integration network take all appropriate steps to ensure that concerns related to long-term care are referred to the ministry through these means; and

“(c) shall provide for the establishment of a provincial long-term-care standards compliance program to,

“(i) monitor the long-term care provided through each local health integration network; and

“(ii) assess, in accordance with uniform performance measurement standards, the quality of the delivery by each local health integration network of specialized long-term-care services.

“Access to services

“(3) The provincial strategic plan shall include, as priorities for the health system,

“(a) the right of individuals to access services that are culturally and linguistically appropriate;

“(b) the obligation of the minister to undertake planning on an ongoing basis to ensure the right described in clause (a); and

“(c) the obligation of the minister to ensure co-ordinated provincial planning of specialized paediatric services across the geographic areas of all local health integration networks.

“Process

“(4) The minister shall set out in a document the process that the minister will use in developing a provincial strategic plan and shall make copies of the document available to the public at the offices of the ministry.

“Consultation

“(5) In developing a provincial strategic plan, the minister shall consult health system users, including patients and consumers, and service providers and have regard for maximizing timely access within each local health integration network high quality health care services.

“Same

“(6) In developing priorities and strategic directions for the health system and the local health systems in the provincial strategic plan, the minister shall seek the advice of province-wide health planning organizations that are mandated by the government of Ontario and aboriginal peoples.”

Now, these amendments have been requested by the Ontario Long Term Care Association, Yee Hong, the Hospital for Sick Kids, the OHA, the GTA/905 Health Care Alliance, Cardiac Care Network, the Noojimawin Health Authority and others. Basically, again, they want to maintain central standards for LTC providers while at the same time allowing LHINs to develop specialized programs at the local level based on local needs.

Experiences in other provinces, by the way, have shown that when you devolve accountability, as we're doing here, there are variations in basic programs and that doesn't always suit the public well. In 2005, the provincial auditor in Alberta questioned the variations in basic LTC programs offered in that province through the local health authorities. The result is that now, the Alberta government having learned that they need to go back, the Alberta Ministry of Health and Wellness has now restated its role in setting province-wide standards. We can learn from that.

Also, if you take a look at Monique Smith's report, 2004, on long-term care, she recommended a central direction for a renewed compliance program. Let's listen to Monique, whom I do respect very much. Let's take a look at Alberta, who recognized they made a mistake and corrected the mistake, and let's make sure we do have these province-wide standards in place.

Access to services: again, common barriers to accessing health care. According to a survey of older Chinese Canadians, that's really important for those people who do not speak the language and have different cultural programs. Again, we need to take into consideration the needs of the cultural minorities that live outside of the LHIN's geographic boundary.

Also, we need to improve coordination within the paediatric system and address the inequities and weaknesses within the current system. We need to better

address the health care needs of children. As I've said before, we're really ignoring these young children.

The legislation currently does not state the process by which the minister shall set out to develop these strategic plans. So we are trying to ensure that the needs, the concerns of all people, including aboriginals and First Nations, are adequately provided for in the LHINs, and that's what this amendment reflects.

1730

The Chair: Any debate? Ms. Wynne.

Ms. Wynne: I know my friend Monique Smith will be pleased to know that you're referring to her report. But I think that a significant part of this amendment actually should be in long-term-care legislation, as opposed to this legislation. There are also other pieces in terms of the relationship with the aboriginal peoples that we're bringing forward in another amendment. So I'm not going to be supporting this amendment, although I understand that Mrs. Witmer is trying to get at some specificity that I think just isn't appropriate in this piece of legislation.

The Chair: Any further debate? If there's none, I'll put the question. Those in favour? Those opposed? It does not carry.

The last amendment is from Ms. Wynne, on page 46.

Ms. Wynne: I move that section 14 of the bill be amended by adding the following subsections:

"Councils

"(2) The minister shall establish the following councils:

"1. An aboriginal and First Nations health council to advise the minister about health and service delivery issues related to aboriginal and First Nations peoples and priorities and strategies for the provincial strategic plan related to those peoples.

"2. A French-language health services advisory council to advise the minister about health and service delivery issues related to francophone communities and priorities and strategies for the provincial strategic plan related to those communities.

"Members

"(3) The minister shall appoint the members of each of the councils established under subsection (2) who shall be representatives of the organizations that are prescribed.

"Consultation

"(4) In developing priorities and strategic directions for the health system and the local health systems in the provincial strategic plan, the minister shall seek the advice of province-wide health planning organizations that are mandated by the government of Ontario."

I had said that we would be bringing forth an amendment that would require the minister to set up these councils to allow him to get advice on priorities and strategies for the provincial strategic plan from the aboriginal, First Nations and French-language communities. This addresses some of the suggestions that were made to us by those groups. This amendment also adopts some suggestions from the Cardiac Care Network in the broadest way, in terms of mandating that the minister consult with those province-wide health planning organi-

zations so that their planning process is caught by the provincial strategic planning process.

The Chair: Any further debate? Ms. Martel.

Ms. Martel: If I might, as I read this section, the reference is only to paragraphs 1 and 2, so I'm not sure how other provincial organizations are captured, unless perhaps I've misunderstood.

Ms. Wynne: If you read subsection—

Ms. Martel: "The minister shall appoint the members ... established under subsection (2)"—

Ms. Wynne: If you read subsection (4), Ms. Martel: "The minister shall seek the advice of province-wide health planning organizations that are mandated by the government of Ontario."

Ms. Martel: Thank you, Ms. Wynne. My apologies.

I made reference to this yesterday when I was moving amendments with respect to aboriginal people. We should have all by now received a letter from the Chiefs of Ontario and the Union of Ontario Indians, saying that the amendments the government is putting forward that affect First Nations people are not acceptable to them. This is one of the two that they have already indicated are not acceptable, and I find it regrettable that the government would move forward with an amendment that First Nations peoples and the organizations that represent them have already said is not acceptable to them.

The Chair: Any further debate? If there's none, I shall put the question.

Ms. Wynne: Could I just say—I think I did address this to some extent yesterday—that I know the minister has had a number of meetings with the First Nations groups, and this is the amendment that has come forward to us as a result of those conversations. I understand that the groups are not completely happy with this amendment—I hear what Ms. Martel is saying; I understand that—but as a result of the conversations with the First Nations groups, this is what has come forward, and I know that there will be an ongoing conversation between the ministry and the First Nations and francophone communities.

Ms. Martel: Sorry. I think it's important to say this is what's coming forward from the government. This is not what's coming forward from aboriginal organizations. We all have a letter in our possession, dated February 9, from the Chiefs of Ontario that makes it very clear they have seen these amendments and have told the government the amendments are not acceptable. So the government chooses to bring the amendment forward, which the government has a right to do, but it comes forward without the support—indeed, it comes forward with the opposition—of First Nations organizations in the province.

Ms. Wynne: And that is regrettable, but what I had intended to mean was that as a result of the conversations that the minister has engaged in, these are the amendments that have come forward, yes, from the government.

The Chair: Any further debate? If there's none, I'll put the question. Those in favour of the amendment? Opposed? It carries.

The section is amended by this last motion. Therefore, shall section 14, as amended, carry? Those in favour? Those opposed? It carries.

Section 15: Madam Martel, page 47, please.

Ms. Martel: I move that section 15 of the bill be struck out and the following substituted:

“Integrated health service plan

“15. (1) Each local health integration network shall, within the time and in the form specified by the minister and in consultation with the community of persons and entities involved with or served by the local health system, develop an integrated health service plan for the local health system and make copies of it available to the public at the network’s offices.

“Contents

“(2) The integrated health service plan shall include,

“(a) a vision, priorities and strategic directions for the health system; and

“(b) human resource adjustment planning, including projections of health human resource need and specific measures to address anticipated shortages of health care practitioners.

“Restrictions

“(3) The integrated health service plan shall be consistent with the purposes of this act, a provincial strategic plan, the funding that the network receives under section 17 and the requirements, if any, that the regulations made under this act prescribe.”

As I moved in an earlier amendment with respect to 14, the intent is to try and broaden those issues that will be dealt with—in this case by the LHIN and in the former case by the minister—as a local strategic plan is developed. Those important issues include not just “a vision, priorities and strategic directions,” but “(b) human resource adjustment planning” at a number of levels. Those things should be taken into account by the LHINs in a formal way through consultation when they develop the local plan.

The Chair: Any debate on the motion? If there’s no debate, I will then ask for a vote. Those in favour of the amendment? Those opposed? It does not carry.

Madam Witmer, please.

Mrs. Witmer: I move that subsection 15(2) of the bill be struck out and the following substituted:

“Contents

“(2) The integrated health service plan shall include,

“(a) a vision, priorities and strategic directions for the local health system;

“(b) a statement as to how the network proposes to meet local health needs across the continuum of care;

“(c) a statement as to how the network proposes to exercise its duties and powers under this act and the regulations made under it, including strategies to integrate the local health system, in order to achieve the purpose of this act;

“(d) a statement as to how the network proposes to measure its performance in achieving the purpose of this act, including objectives and targets for the local health

system, and when these objectives and targets will be met;

“(e) a financial plan, including a statement of how the network will allocate resources to meet the network’s priorities, objectives and targets for the local health system and to meet provincial priorities;

“(f) a statement as to how the network proposes to support and facilitate provincial programs and services;

“(g) an assessment of the impact of the integrated health service plan on health service providers, including strategies to support research, health human resource planning and education; and

“(h) a plan to ensure local access to such services as are prescribed by the minister having regard to the population size and population characteristics in the area of jurisdiction of the local health integration network.”

This is requested by the Ontario Hospital Association and also by the GTA/905 Health Care Alliance. Unfortunately, the legislation, as currently written, provides little detail on the required content for the integrated health service plan that is to be developed by the LHINs. Given that the IHSP will be the basis for community consultation and integration decisions, it is critical that this section be as precise as it possibly can be. Thus, it should include statements on how the LHIN proposes to meet its responsibilities as well as the needs of the community, how it will spend its money, how it proposes to measure its performance, how it will support provincial programs that we’ve talked about, and the impact the plan will have on providers, research, education and human resource planning. This would meet those objectives.

1740

The Chair: Any debate?

Ms. Wynne: I appreciate the detail in the amendment. I think the intention of the plan is that it would be a strategic plan, so some of the things envisioned by this amendment actually wouldn’t be part of that kind of high-level document. So I won’t be supporting this.

The Chair: Any further debate? I’ll put the question. Those in favour? Those opposed? The motion does not carry.

Mrs. Witmer, 48b, please.

Mrs. Witmer: I move that section 15 of the bill be amended by adding the following subsection:

“Duty of network

“(2.1) The integrated health service plan shall include, as a priority for the local health system, the requirement that the local health integration network ensure the promotion of the mental health of the population within the geographic area and the provision of high-quality services for patients with mental illness and addictions in the area.”

Again, it’s from the Canadian Mental Health Association, CAMH and the Ontario Federation of Community Mental Health and Addiction Programs. I very strongly support the recommendation that the provincial strategic plans must include provisions on mental health and addiction services to ensure that they are included at all

times. I've told you why I feel so. We just have to remember that this is a vulnerable sector, and we need to confirm that the needs are going to be addressed.

The Chair: Any debate? If there is none, I will put the question. Those in favour of the amendment? Those opposed? The amendment does not carry.

The section is not changed, so I'll take a vote on it. Shall section 15 carry? Those in favour? Those opposed? The section carries.

Section 16: Mrs. Witmer, page 49, please.

Mrs. Witmer: I move that subsections 16(1) and (2) of the bill be struck out and the following substituted:

"Community engagement

"16(1) A local health integration network shall engage the following persons and entities about that system on an ongoing basis, including about the integrated health service plan and while setting priorities:

"1. The community of persons and entities involved with the local health system, including health service providers and the people they serve.

"2. The persons and organizations mentioned sub-clause 5(1)(h)(ii).

"Experts in public health

"(1.1) In carrying out the community engagement described in subsection (1), a local health integration network shall engage experts in issues of public health.

"Principles for engagement

"(1.2) A local health integration network shall respect the following principles in carrying out the community engagement described in subsection (1):

"1. Reasonable notice to the community.

"2. Sharing information to allow meaningful participation of the community.

"3. Reasonable time and opportunity for the community to respond and make submissions to the network.

"4. Inclusiveness and accessibility.

"5. Clear communication and adequate feedback during community engagement.

"6. All other prescribed principles.

"Health professionals advisory committee

"(2) Each local health integration network shall establish a health professionals advisory committee and shall appoint to it at least one member from each regulated health profession.

"Same

"(2.1) Despite subsection (2), a health professionals advisory committee established under that subsection shall include at least one representative of approved agencies within the meaning of the Long-Term Care Act, 1994.

Again, this is coming from Bloorview MacMillan Children's Centre, CCN, OHA, city of Toronto, Ontario Long Term Care. It sets out a definition of community as including the people who need to be included. It speaks to the need for province-wide consultation to engage public health experts in planning. It sets out, as I say, the principles for community engagement. It establishes the membership of the health professionals advisory committee.

The Chair: Any debate? If there is no debate, I will put the question. Those in favour? Those opposed? It does not carry.

Ms. Wynne: I move that subsection 16(1) of the bill be amended by adding "diverse" after "community of."

What this does is recognize the multicultural and multilingual nature of communities across the province with which the LHINs will be consulting. It addresses an issue that was raised by a number of groups in the hearings.

The Chair: Any debate? I'll put the question, then. Those in favour? Those opposed? It carries.

Ms. Martel, there is a replacement page 51.

Ms. Martel: I move that subsection 16(2) of the bill be struck out and the following substituted:

"Advisory committees

"(2) Each local health integration network shall establish,

"(a) a health professionals advisory committee consisting of front-line regulated health professionals who provide health care within the geographic area of the network;

"(b) a health workers advisory committee consisting of front-line health sector employees who provide health care within the geographic area of the network; and

"(c) a community advisory committee consisting of, at a minimum, seniors, mental health consumers and consumers of community support services and, with respect to each of those classes, representatives of organizations that advocate for the interests of the class.

"Requirements

"(2.1) With respect to each committee required under subsection (2), a local health integration network shall,

"(a) appoint persons to each committee who are representative of the class of persons that the committee is required to consist of; or

"(b) if the class of persons that the committee is required to consist of is typically represented by a certified bargaining agent, invite every trade union that is a certified bargaining agent for that class in the geographic area of the network to select persons who shall be appointed to the committee."

We heard a lot of concern during the course of the public hearings about consultation and where the LHINs would get their advice. The legislation as drafted talks about the LHIN being required to get advice from a health professionals advisory committee, which is appropriate, but doesn't go much further than that—at least before some of the amendments today.

It's my sense and my feeling that there should be some other committees that could be established that would also be required to request input/advice from the community with respect to decisions that the LHIN wants to make or other advice they need in terms of carrying out their work. So we've specifically added an advisory committee that would consist of front-line health care workers, who, as we heard during the course of the public consultations, desperately need to be involved in processes where change is anticipated. They are the ones

who are on the front line, providing care, and have a wonderful contribution to make in this regard; and we should be talking to a broader range of representatives from the community at large who are neither health care professionals nor working in providing care but those who are recipients of that care in that geographic network.

I have outlined “at a minimum, seniors, mental health consumers and” those who use community support organizations, again with the intention that the LHINs could add others but, at a minimum, representatives from those classes and/or organizations who advocate for them should be on an advisory committee. It’s very clear that the LHINs, under the legislation, are going to have some quite significant powers that the minister has granted them. They should be in a position to get the broadest possible advice from those who shall be affected, because they’re delivering the service or because they’re recipients of the service.

The intention is to make sure that there isn’t just one advisory committee made up of health professionals but two others from where that advice, information and input could be solicited on an ongoing basis.

The Chair: Any debate?

Ms. Wynne: The next government amendment actually suggests a process for community engagement that’s broader, that isn’t quite as specific. As I look at this amendment from Ms. Martel, there are some very specific suggestions, but it doesn’t give the LHIN the flexibility it needs to set up the appropriate advisory committees for its community. So I won’t be supporting this amendment.

The Chair: Any further debate? If there’s none, I’ll put the question.

Those in favour? Those opposed? It does not carry.

Ms. Wynne, page 52, please.

1750

Ms. Wynne: This is the amendment to which I was just referring.

I move that section 16 of the bill be amended by adding the following subsections:

“Definition

“(1.1) In this section,

“‘community’ includes, in respect of a local health integration network that engages the community,

“(a) patients and other individuals in the geographic area of the network,

“(b) health service providers and any other person or entity that provides services in or for the local health system, and

“(c) employees involved in the local health system.

“Methods of engagement

“(1.2) The methods for carrying out community engagement under subsection (1) may include holding community meetings or focus group meetings or establishing advisory committees.

“Duties

“(1.3) In carrying out community engagement under subsection (1), the local health integration network shall engage,

“(a) the aboriginal and First Nations health planning entity for the geographic area of the network that is prescribed; and

“(b) the French language health planning entity for the geographic area of the network that is prescribed.”

Some of you may have more in this amendment, but that has been withdrawn, so that’s the end.

This amendment responds to the numerous comments we got from groups. Most of the groups agreed that there needed to be more specificity in the bill about what we meant by “community engagement.” The challenge was to put in some specific comments without tying the hands of the LHINs. We believe that this amendment does that. It’s a non-exhaustive list and definition of what we mean by “community engagement.”

The Chair: Mr. Leal, did you want to add something to the explanation?

Mr. Leal: I just want a recorded vote, please.

The Chair: Okay. Let’s see if there’s any debate.

Ms. Martel: Part of the effort in the previous amendment that I put was to ensure that very specific groups that are primary users of the system or those who have had to struggle to access health care services would have to be included, that there would be a requirement. We know, because we heard from the many seniors’ organizations that came before us, that they are primary users of the health care system and that is going to continue. Secondly, we heard from numerous groups that represent those who access mental health services, or survivors, that mental health is a poor second cousin. It has to fight very hard to compete for dollars and for any kind of recognition in the health care system. Throughout this whole process, if we were going to ensure that their voices didn’t get lost, we had to do something very specific to ensure that they would be consulted.

I differ with the government in terms of the amendments as they’ve been placed. My concern is that there is no requirement under the government amendment for a LHIN to actually ensure that there is a senior on their advisory committee, that there is a consumer of mental health services. That is not defined, and that is why I said very clearly in my amendment that each of these classes at a minimum should be represented. The LHIN can have other patients who have other experiences, but at a minimum, surely we should be protecting some of the prime users of the system and some of those folks whose voices have traditionally been lost when they’ve been trying to access some of these services; that is, both seniors and those who are accessing mental health services.

I also included community organizations because we heard from very many of those during the process, organizations that represent people who use Meals on Wheels, home care etc. That is a broad cross-section of the community and somebody from that section should as a requirement be providing advice; if not a consumer then at least a representative from a community-based organization that delivers those important community-based services, different from hospital services.

Mrs. Witmer: Given that this is the only opportunity we have to speak to this particular issue of community and community engagement, it's the best that we have, so I will be supporting it. I don't believe that it is ideal and I would support many of the comments that have been made by Ms. Martel.

Ms. Wynne: I'd just like to make a comment. It's interesting: In the area that I represent, there are already seniors who are starting to get together to form a group and they're going to be very active in their participation in the LHIN. There are groups that aren't that active, and I think this amendment leaves the door open for the local health integration network to determine the groups that need to be represented. Youth, for example, have not been talked about a lot in these hearings because they didn't come and speak to us, because they're not necessarily organized in the same way that seniors are. But that doesn't mean that they don't need to have a voice at the table and we don't need to make sure that they're included. I think having a more flexible, more open-ended and clear process is the way we should go. That's why this amendment is being put forward.

The Chair: Any further debate? If there's none, I will now put the question.

Ayes

Craitor, Leal, Martel, Ramal, Witmer, Wynne.

The Chair: Everybody is in support.

The next is from Ms. Witmer: 52(b).

Mrs. Witmer: I move that section 16 of the bill be amended by adding the following subsection:

"Physician advisory committee

"(2.1) Each local health integration network shall establish a physician advisory committee consisting of persons that the network chooses with its geographic area as representatives of legally qualified medical practitioners in Ontario.

"Same

"(2.2) The physician advisory committee shall provide medical advice to the local health integration network that established it on the management structure of the network."

This amendment has been specifically requested by the Ontario Medical Association. They did appear before us. This would address the fact that at the present time there is no specified role for physicians to provide independent input despite the fact that they are involved in all aspects of the health care system. This provides a role to allow them to be involved in the management organization of the health care system. Unfortunately, the health professionals advisory committee is insufficient to respond to the request made by the doctors.

Again, I would just take you back. In Alberta and British Columbia they have learned on their own personal experience that there was a failure when they were not able to directly engage physicians. It resulted in

a less than perfect process. We have an opportunity to be proactive and learn from the BC and Alberta experience.

The Chair: Any debate?

Ms. Wynne: Could I just comment that when the physicians came before us, we did talk about the need for there to be a multidisciplinary health advisory committee, and I think that remains my position, certainly in terms of what would be best in terms of advisory for the LHINs.

Mrs. Witmer: I would just say in response that this amendment has come from the OMA. They believe this is in the best interests of patients and the public in the province of Ontario.

The Chair: Further debate? If there is none, I'll put the question. Those in favour? Those opposed? That does not carry.

The last one in this section is Ms. Wynne, page 53.

Ms. Wynne: I move that subsection 16(3) of the bill be amended by adding "diverse" after "community of."

I spoke to this amendment. It's similar to a previous amendment.

The Chair: Any debate? No. Therefore, I'll put the question. Those in favour? Opposed? It carries.

We'll take a vote on the section. Shall section 16, as amended, carry? Those in favour? Those opposed? It carries.

Section 17: Ms. Martel, page 54.

Ms. Martel: I move that subsection 17(1) of the bill be amended by adding at the end "and may consult a local health integration network and the community of persons and entities involved with the local health system for that purpose."

This section refers to the funding that will be made available to the local health integration networks to provide services within the LHIN geographic boundaries. The current wording that appears in the bill is that the minister may provide funding to LHINs on the terms that the minister considers appropriate. The rationale for the amendment is to also afford the opportunity for the minister to actually have some consultation with both persons and entities in that LHIN about what is an appropriate level of funding for that particular LHIN.

The Chair: Any debate?

Ms. Wynne: I don't think this amendment is necessary. The minister is going to get guidance through consultations on the provincial plans and the LHINs when they submit their health service plan, and he can seek advice as he needs it. So I don't think it's necessary.

1800

Ms. Martel: I guess the problem is that we don't even know what the structure of the provincial strategic plan is right now. What consultation is going to be involved? Who's being consulted? Who's participating? We have had absolutely no information about the development of the provincial strategic plan through the course of these hearings, so I don't know what the minister's going to ask people to provide him. I don't know who's going to be asked. I don't know who's going to participate.

The provision, as it stands here, is not a requirement, but it does give him the opportunity to request input, at

least from those who live in the LHIN area, about what financial resources they think are required to provide services in that area. I don't know—none of us know—what the mechanism is for consultation, input or requests for funding or funding levels at this point, because we haven't been given the details of the provincial strategic plan. That may well not be taken into account. There may not be a public forum, a public process, for questions and issues of funding to actually be dealt with by the community at large.

Ms. Wynne: The point is, though, that the minister doesn't need this section in this bill to be able to talk to whomever he chooses to speak to. That's what I mean. I don't think it's necessary. The idea is that the planning process is from the bottom up, so that the LHIN process will inform what goes on provincially. So I just don't think it's necessary.

The Chair: Any further debate? I will now put the question. Those in favour of the amendment? Those opposed? It does not carry.

Mrs. Witmer, pages 55, 55a.

Mrs. Witmer: I move that subsection 17(2) of the bill be struck out and the following substituted:

"Savings by a network

"(2) When determining the funding to be provided to a local health integration network under subsection (1) for a fiscal year, the minister shall reinvest savings generated by the local health integration network in the previous fiscal year in that network, for the network to spend on patient care in subsequent fiscal years in accordance with the accountability agreement.

"Same

"(3) Reinvestment of savings in a network under subsection (2) shall be in addition to the funding that would have been provided to the network under subsection (1) but for the reinvestment.

"Accountability for funding

"(4) The minister shall ensure that a document explaining the criteria, formulae and other data and considerations that are used as the basis for determining the level of funding provided to each local health integration network under subsection (1) is prepared and that the document is updated whenever there is a change in the basis for determining the level of funding to the local health integration networks.

"Same

"(5) The minister shall ensure that each version of the document referred to in subsection (4) is available to members of the public.

"Same

"(6) Without limiting the generality of subsection (5), the minister shall take such steps to ensure that members of the public can access each version of the document referred to in subsection (4) from the ministry and from each local health integration network."

This ensures that the minister keeps the savings within the LHIN that achieved them, and it provides an incentive for the LHINs to look for efficiencies that they can reinvest in patient care through enhanced or expanded

services. They should not be penalized for being efficient. It also requires that the minister set out in writing the basis for funding decisions with respect to LHINs, and that these plans must be available to the public and updated annually.

I think this is important. We really need to make sure that funding decisions—as the government likes to say, there's a need for openness and transparency—can be appropriately addressed during consultations with the public.

The Chair: Any debate?

Ms. Wynne: What this amendment would do is remove the minister's discretion. I think what's necessary is that the consideration—as the legislation is written now, the minister can consider reinvestment but has to consider that in the context of the government's financial situation. I think we need to leave that flexibility in place and leave the responsibility for that with the minister. So I won't be supporting this amendment.

The Chair: Any further debate?

Mrs. Witmer: Throughout the course of the debate on this bill and since the introduction of the bill, we've heard a lot of people say that this legislation gives tremendous power to the Minister of Health. It is beyond anything that we've ever seen in Ontario, and I think the comments I've just heard from Ms. Wynne certainly confirm that. I guess we want to make sure that there is efficiency within the LHINs, otherwise you're going to have what happens in every other organization: People are going to spend the money, and it might not be spent wisely. This is taxpayer money, and I think we need to take a look at if you have savings, you can use it to improve patient care.

The Chair: Any further debate? If there is none, I'll put the question. Those in favour of the amendment? Those opposed? It does not carry.

Madam Martel, page 56, please.

Ms. Martel: I move that subsection 17(2) of the bill be struck out and the following substituted:

"Savings by a network

"(2) When determining the funding to be provided to a local health integration network under subsection (1) for a fiscal year, the minister shall not treat any savings from efficiencies that the local health system generated in the previous fiscal year as a reason to reduce funding for the fiscal year in question."

This follows from the previous amendment that was moved by Mrs. Witmer. I decided to move this amendment as a result of a presentation and a discussion I had with the Ontario Association of Community Care Access Centres, which came before the committee and said that they were very supportive of section 17 of the bill, because from their perspective it meant that any savings that were realized could be kept and reinvested in the LHIN. I asked them very specifically where in the legislation, in subsection 17(2), it said just that. The reality is that there's nothing in subsection 17(2) that says that the minister will allow a LHIN to keep the savings it has generated and have those savings in addition to a

particular amount of money that he or she—that is, the minister—was going to provide. On the contrary, the section is broad enough to also have the minister deduct the amount of the savings that have been realized from an amount of money that he or she proposed to provide to a LHIN in a fiscal year.

The amendment I'm moving makes it absolutely clear that the minister will not have that discretion, that indeed if a LHIN has savings in a fiscal year, those savings will be used by the LHIN, they will be given to the LHIN, and they will not be deducted from a global amount of money that the minister might have provided to the LHIN in the fiscal year. The amendment makes it very clear that if there are savings, they go to the LHIN, and the minister cannot deduct those savings from the funding that he or she would have otherwise provided to the LHIN in the fiscal year.

Ms. Wynne: What this section in the bill does is allow for the possibility for the minister to adjust after there have been savings realized. It's interesting, in the hearings, there's been an inherent contradiction. On the one hand, there have been people who have said, "We're not happy with the LHIN structure because it takes away control from the Ministry of Health," presumably because people were arguing for the status quo; on the other hand, there have been people who have said that there's too much control in the hands of the minister. I think what we're trying to do is write a piece of legislation that recognizes that control of the financial well-being of the health system in the province rests with the minister. That is the minister's responsibility. So we need to have in place enough of a framework that will allow the minister to make those final decisions and hold on to that discretion and at the same time have the local planning process in place. That's why I won't be supporting this amendment. We're trying to find that balance.

Ms. Martel: Subsection 17(2) certainly talks about "adjust," but it can be an adjustment upward, so you get your global amount of money and your savings, or an adjustment downward, so you get your global amount of money minus the savings that you achieved. To be clear that this exercise is not about cost-cutting and the government saving money from the health care budget, I would think the government would want to make it clear that any savings that have been achieved by a LHIN would be reinvested in health care. Otherwise, it's very clear—the concerns people have raised—that this bill and the powers in it are all about cost-cutting and finding savings that the government can use from health for other purposes. Many people came forward and said, i.e., to balance a deficit before the next election.

1810

If you want to make sure that the Ontario Association of Community Care Access Centres was right in its support, you would want to make a change to make it very clear that the minister retains funding, because the minister of course will set the global amount of money that is provided each year. He or she continues to have the ability to do that. That's not restricted. The restriction

is ensuring that any savings that are realized won't be deducted from that global amount of money that the minister still has the discretion around in terms of determining what it is that will be provided every fiscal year.

Ms. Wynne: Just a final comment. There are other factors in this. There's an accountability agreement. There's a plan that the LHIN has put in place, so that the savings and what happens to those savings are in accordance with what's in the accountability agreement and what the longer-term plan is. I think those are the checks and balances, and I'll end it there.

The Chair: Any further debate? If there is none, I'll put the question.

Ms. Martel: Recorded vote.

Ayes

Martel, Witmer.

Nays

Fonseca, Leal, Ramal, Wynne.

The Chair: The motion does not carry.

Ms. Martel, page 57, please.

Ms. Martel: I move that section 17 of the bill be amended by adding the following subsection:

"Funding details

"(3) The minister shall make details of the funding he or she provides under this section available to the public at the offices of the ministry and shall publish them on the ministry's website."

The purpose of the amendment is to ensure that those who live in a geographic area serviced by a LHIN are made aware of the exact amount of money that has been transferred to a LHIN in a fiscal year. It is public money and the public is entitled to that information. This amendment would make it clear that the amount of money that has been transferred from the ministry down to the LHIN is available publicly to those who would want to access that information.

The Chair: Any debate?

Mrs. Witmer: I will support it.

The Chair: Any comments? If there's none, I'll put the question.

Ms. Wynne: Can I just comment that accountability agreements are going to be made public under section 18. The details of the funding are in the accountability agreements, so they will be public.

Ms. Martel: Can I get a clarification?

The Chair: From staff?

Ms. Martel: From staff perhaps, if you don't mind. I apologize, I don't know what motion that's coming forward talks about accountability agreements, so I'd like to know what the reference is to be sure that that does say that the amount of money will be published; not just the terms and conditions in the agreement but what the

amount is. I just don't know where that is, so I'd like to see it, please.

Ms. Wynne: Just while they're getting the section, just to Ms. Martel, are you asking the specificity of subsection 18(5) or the clarification of 18(5)?

Ms. Martel: No. You've said that the accountability agreements will be made public.

Ms. Wynne: Which is in 18(5).

Ms. Martel: And that the amount of money will be made public through the publishing of the accountability agreements. I don't know where that reference is, so I'd like to be clear that that's the case, so then I know that my amendment is redundant.

Ms. Tracey Mill: I wouldn't say that. Tracey Mill, director of the LHIN legislation project, Ministry of Health. In clause 18(2)(d) is the requirement for a plan for spending the funding of the network to be included in the accountability agreement. Then in subsection 18(5) there's a requirement for the accountability agreement between the minister and the LHINs to be made public. Then there is a proposed government motion, 122a, that would require that the minister and the LHIN establish a public website and publish on those websites any documents, any plans, agreements or anything that is required under this legislation.

Ms. Martel: That responds to information that has to be publicized. If I can go back to clause 18(1)(d), it's the information that has to be made public that I'm interested in. So when it says "a plan for spending the funding that the network receives under section 17," we should assume that that will clearly outline all of the spending that the LHIN will do with the exact amount of money they have received? Is that what that means? Because that would be the only way you could find out how much money it actually received, correct?

Ms. Mill: That's what is intended: What money is the LHIN receiving and where is it spending that money?

Ms. Martel: Okay, that's what's intended. Is there any way to make that clearer? The spending I can see, because I'm assuming they're going to set forward, "We're going to give this much to hospitals, this much to home care."

Ms. Mill: There is also the public accounts that require an itemization of the spending, so in addition to the requirement in the accountability agreement, there is also the requirement for the LHIN's spending to be enumerated in the public accounts.

Ms. Martel: Public accounts aren't usually posted on the ministry website, though, are they, in the same way you're going to post the accountability agreement?

Ms. Mill: That's correct.

Ms. Martel: I'd feel a whole lot better if it was articulated very clearly that the exact amount of money they received is outlined. The ministry tells me that's what the intent is, so I'll have to live with that.

The Chair: Any further debate? I will now put the question. Those in favour of the amendment? Those opposed? It does not carry.

No amendment to section 17, so shall section 17 carry? Those in favour? Those opposed? It carries.

Section 18: Madam Witmer, please, page 58.

Mrs. Witmer: I move that section 18 of the bill be amended by adding the following subsection:

"Same

"(1.1) Each accountability agreement entered into under subsection (1) shall be consistent with any agreements entered into between the minister and a person or organization mentioned in subclause 5(1)(h)(ii)."

Again, it is coming from CCN. It's consistent with earlier attempted amendments that failed and ensures that accountability agreements between the minister and LHINs are consistent with the agreements entered into between the minister and these province-wide organizations.

The Chair: Any debate? If there is none, I will put the question. Those in favour of the amendment? Those opposed? It does not carry.

Madam Martel, page 59.

Ms. Martel: I move that subsection 18(2) of the bill be amended by adding the following clause:

"(d.1) a requirement that the network spend any savings from efficiencies generated in one year on patient care in subsequent fiscal years;"

This follows from a previous amendment that would have made it clear that savings could not be deducted from a global amount of money provided to the LHINs in any given fiscal year. This amendment would have made it clear as well that the savings themselves would have to have been put back into patient care in that LHIN district.

The Chair: Any debate? If there is no debate, then I will put the question. Those in favour? Those opposed? It does not carry.

Madam Witmer, it's page 60, please, subsection 18(3).

Mrs. Witmer: I move that subsection 18(3) of the bill be struck out and the following substituted:

"If no agreement

"(3) If the minister and a local health integration network are unable to conclude an accountability agreement through negotiations, they shall follow the prescribed process for entering into an accountability agreement."

The arguments I'm going to put forward and the recommendation come from the Registered Nurses Association of Ontario. As you know, currently, if there's no successful conclusion of an accountability agreement, the minister has the power to impose. This would amend the bill, recommended by RNAO, for a dispute resolution process when there is no agreement. This would ensure that a LHIN's autonomy is not undermined by the provision of the minister to set the terms of the agreement solely. It's a vehicle I would support.

The Chair: Any debate? If there is no debate, I will put the question. Those in favour? Those opposed? It does not carry.

Madam Martel, page 61.

Ms. Martel: I move that subsection 18(5) of the bill be struck out.

This was done because a previous amendment was moved that would have outlined very clearly the list of

the requirements for the LHINs to be accountable, what would be on the website, what would be posted, the nature of the meetings, reports, documents, information etc. that would be required, but that wasn't accepted so this won't be either.

1820

The Chair: Therefore, there is no amendment to section 18, so we'll take a vote on it. Shall section 18 carry? Those in favour? Those opposed? It carries.

Section 18.1 is a new one. Madam Martel.

Ms. Martel: Actually, in reference to 18.1, I think I have these backwards in my book.

The Chair: Page 62.

Ms. Martel: My apologies to the members. The reference to the previous amendment, 18(5), had to do with the amendment that's now before us. I'll just place it.

I move that the bill be amended by adding the following section:

"Accountability to the public

"18.1 Each local health integration network shall establish and maintain a website on the Internet and shall publish on its website,

"(a) the accountability agreement required under section 18;

"(b) every service accountability agreement it has entered into;

"(c) details relating to the funding it receives under section 17 and the funding it provides under section 19;

"(d) details relating to integration decisions and proposed integration decisions under part V;

"(e) notice of meetings of its board of directors and the meetings of its committees;

"(f) any information it disseminates as part of its objects or otherwise; and

"(g) all reports, plans or other documents it is required to prepare under this act."

My apologies to the members. This probably should have come before the other one. The point was to make it very clear that each LHIN shall maintain a website and sets out those articles or items that have to be on the LHIN's website for access by the public. It is quite broad, including accountability agreements, service agreements that it's entering into with individual health care providers, and other details that are listed, so that the public clearly has an idea of what organizations the LHIN has a relationship to, what are the responsibilities of the parties, and other decisions that the LHIN wants to make with respect to integration, its meetings etc. So in the broadest possible way, these are some of the criteria—there may be more—that we could think of that should have to be posted for public consumption.

If this would be accepted, then 18(5) would be redundant. My apologies. I had those backwards.

The Chair: Ms. Wynne.

Ms. Wynne: We've brought forward amendment 122a. I think Ms. Martel just had that conversation with staff. So 122a does virtually all of this. It puts the proposed public notice requirements out in the legislation, so I won't be supporting 62.

The Chair: Any further debate?

Ms. Martel: Is Ms. Wynne referring to a different section, because 122a doesn't list what's going to be posted?

The Chair: Staff can assist us on this.

Ms. Mill: The requirement for the accountability agreement is in 18(5), as I mentioned, and is then again referred to in the proposed motion on 122a. The requirement for publishing the service accountability agreement—sorry, I'm just looking for that motion.

The proposed government motion number 140 requires the service accountability agreement that would be negotiated between the LHIN and the health service provider to be made public, as well as a requirement for the health service provider to make the service agreement available at each of its sites of operation. Then, again, government motion 122 would require that to be posted on the website.

Paragraph (c) regarding the funding is the one that we just discussed, so it's 18(2), paragraph (d), and then again motion 122a.

The details regarding the integration decisions: The government is proposing to introduce motions regarding that. I'll just get those references for you. They are government motions 94 and 98, which deal with the integration decisions and a requirement for those to be made public. Then, again, motion 122a would require the posting on the website.

The Chair: Thank you. Any debate? If there's none, I will now put the question. Those in favour of the amendment? Those opposed?

Ms. Wynne: Could you just call the motion we're on?

The Chair: We are on 62.

Ms. Wynne: Okay. Sorry.

The Chair: I'll take the vote again. Those in favour of the amendment, which is 18.1, the new section? Those opposed? It does not carry.

This is a new section, so we don't need a vote on it.

Section 19: Madam Witmer, page 63 for you.

Mrs. Witmer: I move that subsection 19(1) of the bill be amended by adding "or in or for an area that includes all or part of the geographic area of the network."

This is from the Association of Ontario Health Centres, and as we know, this would apply to certain health providers such as community health centres that are mandated to provide services across LHIN boundaries. Integration and funding decisions obviously must reflect the need to accommodate the transience of many of their clients. This is seen as being crucially important in a community such as the city of Toronto, because we did not adopt the amendment to make Toronto one big LHIN. So they're currently going to be serviced by five separate LHINs.

The Chair: Any debate?

Ms. Wynne: I wasn't exactly clear about what the official opposition was trying to get at with this amendment, but my understanding is that in the objects, 5(g), the LHINs are required to develop strategies and co-operate with other local health integration networks. That

cross-LHIN process is already in place, so I'm not sure what this would accomplish in addition to that.

Mrs. Witmer: I'll take your word for it.

Ms. Wynne: Thank you.

The Chair: So we'll still take a vote on it. Those in favour of the amendment? Those opposed to the amendment? It does not carry.

We go to Mrs. Witmer, page 64.

Mrs. Witmer: I move that section 19 of the bill be amended by adding the following subsection:

"Long-term care

"(1.1) The funding that a local health integration network provides to health service providers under subsection (1) shall include specialized funding for long-term care based on the unique needs of the relevant local population."

Obviously, it's from the Ontario Long Term Care Association. They believe LHINs should have the responsibility for granting funding for specialized programming that relates to their specific local population and that it should be up to each LHIN to determine the need and appropriate provider to deliver specialized programs that could include dialysis, developmental disabilities, psycho-geriatric convalescent care. This approach would encourage community partnerships among the different health service providers, which would aid the LHINs in addressing their mandate of achieving health integration.

The Chair: Any debate?

Ms. Wynne: I think that the concern here would be that we're focusing on one set of providers and not others. So there's a question of why we would do that. I won't be supporting this amendment.

The Chair: Any further debate? If not, I will put the question. Those in favour? Those opposed? It does not carry.

Mrs. Witmer again, page 65.

Mrs. Witmer: I move that subsection 19(2) of the bill be amended by adding, after "considers appropriate," "following consultation with health service providers."

Again, this is from the Ontario Long Term Care Association. This would require the LHIN to consult with health service providers to help determine the funding that is appropriate for specialized programs. Of course, the other amendment was lost. So I withdraw this.

1830

The Chair: We withdraw this one.

Page 66. Again you, Mrs. Witmer.

Mrs. Witmer: This is a big one.

I move that section 19 of the bill be amended by adding the following subsections:

"Same

"(2.1) Despite subsection (2), the funding that a local health integration network provides under subsection (1) shall be subject to the condition that the allocation of the funding,

"(a) reflect the needs of persons with special needs for services relating to such factors as culture and language; and

"(b) be adequate for facilities with province-wide mandates and programs.

"Funding principles

"(2.2) In providing funding to a health service provider under subsection (1), a local health integration network shall consider the following principles:

"1. Equitable access to the continuum of care.

"2. Meeting health care needs across the continuum of care.

"3. High quality care.

"4. Fiscal accountability and sustainability.

"5. Efficiency in the context of value for money.

"6. Equitable and transparent allocation of funding.

"7. Multi-year funding to ensure stability and predictability of health service provider operations.

"8. Consistency with the integrated health service plan, the provincial strategic plan, provincial funding policies, provincial programs and services and other provincial plans and standards, and the roles and responsibilities of the health service provider.

"9. All other prescribed principles."

This is coming from Yee Hong, Sick Kids, OHA and Bloorview MacMillan. There is some concern that without these types of specific requirements taken into consideration, the needs of some of the service users outside of their catchment areas to access culturally appropriate services, for example, might be at risk. Also, Sick Kids believes that the funding model must recognize and address the increased financial burden that would be placed on facilities like Sick Kids which, as you know, treat the children who have the highest acuity. They believe there is a need for a streamlined method of funding to address the volume of children that they see.

This amendment enshrines the funding principles that have been arrived at over the last several years between the OHA, the joint policy and planning committee and the Ministry of Health and Long-Term Care. The emphasis is on multi-year accountability, sustainability, value for money and these principles which have been established. As I just said, it is believed—and I would support it—that they must be carried over to the new funding arrangement between the LHINs and the health service providers.

The Chair: Any debate?

Ms. Wynne: Mrs. Witmer's got a lot more of the history than I do, but my understanding is that the funding formulae are still under development, that those principles aren't all in place. There have obviously been long discussions, but they're ongoing. To include this amendment would perhaps prejudice that process. So on all these issues, I won't be supporting the specificity around funding.

Mrs. Witmer: I appreciate what Ms. Wynne is saying, but you can well imagine that the stakeholders in Ontario must be somewhat fearful that all of the funding arrangements that are currently in place could be changed, and at the end of the day, they may receive less funding than they currently receive; there is not a lot of

stability and security in the system. But anyway, I do acknowledge and accept that point.

The Chair: Any further debate? If not, I will put the question. Those in favour? Those opposed? It does not carry.

Mrs. Witmer, page 67.

Mrs. Witmer: I move that subsection 19(3) of the bill be amended by striking out “including” and substituting “other than.”

Again, from the OHA and Bloorview MacMillan. This amendment and the one that immediately follows are two parts of the same amendment. The legislation currently allows the minister to assign his rights under all or part of an agreement. This could then extend to include agreements such as hospital on-call coverage and the alternate payment agreements, even though doctors are not considered providers under this bill.

Since these agreements are now centrally negotiated and the physician services will be centrally governed, these agreements, to which physicians are a party, must remain centrally administered. This amendment and the one that follows will ensure that that is the case.

The Chair: Thank you. Any debate?

Ms. Wynne: Could I just ask Mrs. Witmer that she look at motion 69, because what 69 does is clarify that 19(3) doesn't relate to agreements for funding physicians.

Mrs. Witmer: Actually, I do have a note here indicating that this might be the same as ours.

Ms. Wynne: Okay.

Mrs. Witmer: There you go.

The Chair: So what do we do? More debate on the matter?

Ms. Wynne: Yes. I won't be supporting this because that one is coming.

The Chair: If there's no more debate, I'll put the question. Those in favour of the amendment? Those opposed? That does not carry.

Mrs. Witmer: I will withdraw that motion.

The Chair: Thank you. Ms. Wynne, page 69.

Ms. Wynne: I move that section 19 of the bill be amended by adding the following subsection:

“Exception

“(3.1) Despite subsection (3), the minister shall not assign to a local health integration network an agreement for the provision of funding for services by a person described in subsection 2(3) that the minister has entered into under the authority of paragraph 4 of subsection 6(1) of the Ministry of Health and Long-Term Care Act or subsection 2(2) of the Health Insurance Act.”

I think I just described what this does.

The Chair: Any debate on this? If none, I'll ask the question. Those in favour? Those opposed? It carries.

Mrs. Witmer, page 70, subsections 19(5) to (9).

Mrs. Witmer: I move that section 19 of the bill be amended by adding the following subsections:

“Long-term care funding

“(5) The minister shall establish provincial rules for the funding of core long-term-care programs in long-term-care homes.

“Same

“(6) The rules shall ensure that the needs of residents of long-term-care homes are met in a fair and accessible manner.

“Same

“(7) The rules shall ensure that each long-term-care home is funded for the home's total capacity of licensed or approved beds.

“Same

“(8) Each local health integration network shall fund long-term-care homes in its area of jurisdiction in accordance to the rules.

“Same

“(9) In the event of a conflict between a discretion as to funding of long-term-care facilities conferred under this act and the requirements of subsections (5) to (8), the requirements of subsections (5) and (6) prevail.”

This is an amendment we've been asked to put forward by the Ontario Long Term Care Association. I'll hearken back to what I said before: Experience in other provinces has shown that when you devolve accountability as we are doing here, you do see variations in basic programs throughout the province. Unfortunately, sometimes some members of the public in certain LHINs then are not served as well as in other communities. For example, that report I referred to before of the provincial auditor in Alberta showed that funding for long-term care across the province of Alberta actually fluctuated by as much as—get this—\$10,000 per head. That's a lot of money. A centralized funding framework such as proposed by this amendment would be crucial to mitigating any differences based on geography. It would provide stability as well for operators and their creditors and it would provide a framework for centralized funding based on beds and would require the LHINs to comply with the centralized funding formula.

Ms. Wynne: I have a couple of comments: As I've said before, the isolating of one sector I think is not appropriate for this legislation. The other issue is, as I've said before, that the funding formulas are being developed. There's another problem with this, as I read it: that this amendment would actually require the government to pay for capacity. It would require the government to pay for beds, whether they were being used or not—pay for empty beds.

Mrs. Witmer: They do that.

Ms. Wynne: Okay; and that's not contrary to the long-term-care program? Can we just check with staff on that issue, please?

1840

Mr. Maisey: Currently, under the long-term-care homes program, if the occupancy is less than 97%, then there's a reconciliation and a clawback so that we don't pay for that capacity.

Ms. Wynne: Right. So there's a threshold a long-term-care home has to reach in order to have the total capacity paid for.

Mr. Maisey: That's right. Then there are some other programs that allow, in certain circumstances, for a home

that meets certain conditions, where its capacity is less than 97%, an extra margin on top of its percentage capacity. I can't remember the name of the program.

Ms. Wynne: But as this is written, is it not that no matter what the occupancy is, the total capacity would have to be paid for? There's no threshold.

Mr. Maisey: That's how we interpreted subsection (7).

The Chair: Any debate? If there is none, I will put the question. Those in favour of the amendment? Those opposed? The amendment does not carry.

Shall section 19, as amended, carry? Those in favour? Those opposed? It carries.

Section 20: Mrs. Witmer, please, page 71.

Mrs. Witmer: Based on earlier discussions, I'm going to withdraw this motion.

The Chair: Ms. Martel, page 72.

Ms. Martel: I move that subsection 20(3) of the bill be struck out.

That is the one section of the bill where patient mobility to access services is not permitted, so removing it from the act would make it clear that there is not a restriction on where patients can access their services, including either hospital services or home care services.

The Chair: Any debate? If there is no debate, then I'll put the question. Those in favour? Those opposed? It does not carry, therefore I'll take a vote on the section.

Shall section 20 carry? Those in favour? Those opposed? It carries.

Section 21: Mrs. Witmer, page 73.

Mrs. Witmer: I move that section 21 of the bill be amended by adding "that have a direct relationship to operations covered by the service accountability agreement" at the end.

This has been requested by the Ontario Long Term Care Association because today some service providers have operations that will only be partially funded by the LHINs; for example municipalities, charitable organizations and private sector companies. As written, the legislation requires providers that receive any funding from the LHINs to submit to audits of their accounts. This amendment will ensure that only those portions of a provider's business that is funded by a LHIN are open to an audit. And they can't audit, obviously, the entire charitable organization, private sector company or the municipality.

The Chair: Any debate? If there is none, I'll put the question. Those in favour? Those opposed? It does not carry.

Shall section 21 carry? Those in favour? Those opposed? It carries.

Section 22: Mrs. Witmer, page 74.

Mrs. Witmer: I move that section 22 of the bill be amended by adding the following subsection:

"Restriction

"(2.1) No regulation made under this act shall prescribe a laboratory for which a licence is issued under section 9 of the Laboratory and Specimen Collection

Centre Licensing Act as a prescribed person or entity for the purpose of subsection (2)."

This is a recommendation put forward by the Ontario Association of Medical Laboratories. If you take a look at the legislation as it's currently worded, it allows for a regulatory change that could require these laboratories to divulge to the LHINs plans, reports or any other information that the LHINs decide they need. It is inappropriate for the LHINs to be able to access confidential business information, especially when there are currently no safeguards whatsoever in place to require that the information they would obtain from these laboratories would be held in confidence. This amendment will prevent regulatory changes requiring the labs licensed under the Laboratory and Specimen Collection Centre Licensing Act from having to provide this confidential business information to the LHINs.

The Chair: Any debate?

Ms. Wynne: I would just ask why. Labs may be a group of providers, but the LHIN needs to get information, so I'm not following the logic at all.

Mrs. Witmer: This is confidential business information. There are no safeguards in place currently. Once the LHIN has this information, there's no guarantee it's not going to be shared with other people.

Ms. Wynne: I would just argue that labs are an important part of the health world and I think that information may need to be accessed, so I'm not going to be supporting this amendment.

The Chair: Any further debate? If there's none, I'll put the question. Those in favour of the amendment? Those opposed? It does not carry.

Shall section 22 carry? Those in favour? Opposed? Carried.

Shall section 23 carry? Those in favour? Those opposed? Carried.

Section 24: Mrs. Witmer, page 76.

Mrs. Witmer: I move that section 24 of the bill be amended by adding the following subsections:

"Same

"(2) In addition, each local health integration network and each health service provider shall, separately and in conjunction with each other, work with the persons and organizations mentioned in subclause 5(1)(h)(ii) to identify the opportunities described in subsection (1).

"Notice

"(3) At least 30 days before identifying opportunities to integrate the services of the local health system under subsection (1), a local health integration network shall give notice in writing to all parties that could be affected by such an integration."

This is consistent with some earlier amendments that province-wide organizations be consulted when integration possibilities are being considered. It would require the potential parties to an integration order to be notified 30 days prior to any consideration process of the potential integration. It would allow for community engagement in order to achieve the integration. This advance notice would allow the health service providers who

might be subject to a potential order to fully participate in the decision-making process and provide their input. It would ensure an open, transparent process and maximize the consultation.

The Chair: Any debate? If there's none, I'll put the question. Those in favour of the amendment? Those opposed? It does not carry.

Shall section 24 carry? Those in favour? Those opposed? Carries.

Ms. Witmer, page 77.

Mrs. Witmer: I move that the bill be amended by adding the following section:

"Restriction on disclosure of information

"24.1 If a health service provider integrates its services with those of another person or entity and a local health integration network obtains information pertaining to the integration, the network shall not disclose the information to another local health integration network or another health service provider unless both the health service provider doing the integration and the other person or entity consent."

Currently, a large number of laboratories in the province have a relationship with hospitals and they provide a range of services through agreements and contracts. These services provided range from management of labs to providing reference testing services. These agreements and contracts contain proprietary financial information. This amendment would allow the LHIN to fully explore integration opportunities, while at the same time protecting proprietary information contained in agreements between the lab and the health service provider.

The Chair: Any debate?

Ms. Wynne: The concern of this legislation is that the dissemination of best practices happen smoothly, and this amendment could provide a barrier to that, truncating the flow of information, so I won't be supporting it.

1850

The Chair: Any further debate? If there's none, I'll put the question. Those in favour? Those opposed? It does not carry.

We'll go to section 25, Ms. Wynne, page 78.

Ms. Wynne: I move that clauses 25(1)(b) and 25(2)(a) of the bill be amended by adding "where at least one of the persons or entities is a health service provider" after "the integration of persons or entities" wherever that expression appears.

The intention was that LHINs could only write integration decisions where at least one party was a health service provider. The previous language was not clear on this, so this is a clarification of that.

The Chair: Any debate? If there's none, I'll put the question. Those in favour? Opposed? Carries.

Mrs. Witmer, page 79.

Mrs. Witmer: I move that section 25 of the bill be amended by adding the following subsection:

"Records of personal health information

"(2.1) Despite the Personal Health Information Protection Act, 2004, an integration decision may require one or more health service providers to transfer or receive

records of personal health information as defined in section 4 of that act.

"Same

"(2.2) If a local health integration network issues a decision requiring a health service provider to transfer records of personal health information as defined in section 4 of the Personal Health Information Protection Act, 2004, the health service provider shall take reasonable steps to ensure that the transfer of the records is undertaken in a secure manner."

This has been requested by the Ontario Hospital Association. As you know, some of the integration decisions that are going to take place are going to require the transfer of personal information, and that may require the consent of individuals before that information is transferred. This would arise when integration decisions do not result in the creation of a successor within the meaning of section 42 of PHIPA.

This is really a practical concern. Requiring providers to obtain individual patient consent presents potentially significant barriers to smooth and efficient integrations. This amendment basically would allow the transfer of personal information to take place when required by an integration decision, despite PHIPA, but it also requires health service providers to ensure the transfer happens in a secure manner. So it's intended to facilitate that, but at the same time provide some protection.

The Chair: Any debate?

Mr. Leal: Mr. Chair, if I could just ask a question to staff.

The Chair: If staff could have a seat, please, at the front.

Mr. Leal: Mrs. Witmer has obviously raised an important issue. Could I just get some confirmation that section 42 of the Personal Health Information Protection Act covers this?

Mr. Maisey: This was an issue that we thought about and considered that section 42 of the Personal Health Information Protection Act would do the trick, and that there would be a successorship when there is a transfer of a service, so records would then be able to be moved under that section, including giving notice to patients or other people whose records are being moved.

The Chair: Any further debate? If there's no debate, then I'll put the question. Those in favour? Those opposed? That does not carry.

Ms. Martel, page 80.

Ms. Martel: I move that subsection 25(3) of the bill be amended by striking out "except as otherwise permitted by law" at the end.

A number of people came before the committee who expressed concerns that part of the result of this bill would be that a number of services that were offered in hospitals would no longer be considered core services and would go out into the community, in some cases without any corresponding funding going out to ensure that people could still access them. You have the spectre that this has already happened, for example, at St. Mike's. They had a psychology clinic in the hospital that

was covered, so a very vulnerable population serviced by St. Mike's. Many people who had mental health problems, for example, could actually access that service and not have to pay. When St. Mike's moved that service out of the hospital and into the community, those costs then had to be borne by clients who still wanted to access the service, because psychology services also are not paid under OHIP, essentially. So that caused a very significant problem for a population that already has trouble accessing services.

The problem is, that is permitted by law currently. So there was nothing that could be done. Those folks were charged a fee, and those who couldn't afford to pay didn't get the service otherwise. A lot of people didn't receive the service any more. The concern that was expressed by a number of groups is that it's all well and good that that might be covered by law, but when that service is moved out of the hospital, it shifts the financial burden on to many patients who may well not be in a position to pay for those services themselves, because they're not covered by OHIP and they're not covered any other way.

The purpose of the amendment is to ensure that that's not the kind of thing that's going to happen under this legislation, that more and more hospital services are essentially offloaded into the community, where people are going to be forced to pay for them out of their own pockets.

The Chair: Any debate? If there is no debate, I will put the question. Those in favour of the amendment? Those opposed? It does not carry.

Madam Martel, 81.

Ms. Martel: I move that section 25 of the bill be amended by adding the following subsections:

"Same

"(3.1) No integration decision shall alter the terms and conditions of a collective agreement binding on an employer who is party to such a decision or of the terms and conditions of employment of the employees of that employer without the agreement of,

"(a) the employees affected; and

"(b) in the case of employees represented by a trade union, without the agreement of the bargaining agent that has bargaining rights in respect of a bargaining unit that is subject to the decision, except as provided by the Public Sector Labour Relations Transition Act, 1997.

"Same

"(3.2) No integration decision shall be issued before the parties to the decision have met with every bargaining agent that has bargaining rights in respect of a bargaining unit that may be affected by the decision and the parties have, in good faith, made every reasonable effort, including, but not limited to mediation, to agree to a human resources plan.

"Same

"(3.3) No integration decision shall permit the transfer of services within the health services sector from a not-for-profit health service provider to a for-profit health services provider.

"Same

"(3.4) No integration decision or funding allocation shall be issued before the local health integration network has given public notice of the proposed decision in accordance with section 18.1 and has provided potentially affected persons and entities to make representations."

This was given to us as an amendment by both the Ontario Nurses' Association and OPSEU. I think it's clear that the focus is to make sure that (a) the integration that's going to go on under this bill is not going to result in a transfer of services from not-for-profit entities to for-profit entities. That would just ensure that health care dollars that should go to patient care instead end up going to profits of some of those for-profit companies. It also makes it very clear what the rights are of affected employees and what efforts have to be made to deal with those employees as integration decisions get carried out. Then there is the notice provision as well, which would allow for the bargaining agent, if there is one, with respect to those employees to work with the employer to agree to a human resources plan so that there's not significant disruption with respect to the services that those employees are trying to provide to the public.

The Chair: Thank you. Any debate?

Ms. Wynne: The concern with this amendment is that it could protract integration processes. Also, we're bringing forth amendment 85, and the PCs have brought forth amendment 84, which actually lays out the need for a human resources plan. So I won't be accepting this amendment.

The Chair: Any further debate?

Ms. Martel: Ms. Wynne, references on both pages 84 and 85 do speak to a human resources plan, which needs to be spoken to in the context of what's happening here. We heard that again and again. Neither of them, however, speaks to the very serious concern that was raised by a number of presenters—not just potentially affected employees, but a number of the seniors' organizations and health coalition representatives—that integration decisions should not result in changes to benefit for-profit health services providers.

The last thing we want to see, if this government truly is committed to Bill 8 and to the Canada Health Act, is an increased proliferation of health care providers. Neither of the two amendments that were referenced by Ms. Wynne speaks to ensuring that integration decisions are not going to result in a transfer of health care services from the not-for-profit to the for-profit sector. I think that should be a serious consideration by this government, one that they would be amenable to accepting.

Ms. Wynne: When we get to the preamble, Ms. Martel will see that there is an amendment we're going to suggest that would frame this whole bill in terms of promotion of a not-for-profit provision.

The Chair: Any further debate? Of course, I would remind you that shortly, I would like this to come to an end, if we want to take a vote.

Ms. Martel: Just very briefly, the preamble states that the principles—this would provide a clear detail in the

bill that would essentially say that that kind of integration decision is prohibited. The preamble as a statement of principle doesn't put that principle into effect. This amendment would put that principle into effect in this section, to ensure that integration decisions will not adversely affect not-for-profit health care delivery or not-for-profit agencies in the province.

The Chair: Any further debate? None? I shall now put the question.

Ms. Martel: Mr. Chair, could I have a recorded vote?

Ayes

Martel.

Nays

Craitor, Fonseca, Leal, Ramal, Wynne.

The Chair: The motion carries—

Ms. Wynne: No, the vote was lost.

The Chair: I'm sorry—lost.

I believe we were going to be here until 7; it's just after 7. We will end this session until tomorrow at 10 a.m. Thank you, goodnight, and a happy Valentine's Day to all of you. Thank you to the minister, or his staff or whoever, for sending us a present here.

The committee adjourned at 1903.

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**Legislative Assembly
of Ontario**

Second Session, 38th Parliament

**Assemblée législative
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Deuxième session, 38^e législature

**Official Report
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Wednesday 15 February 2006

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Mercredi 15 février 2006

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**Comité permanent de
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STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Wednesday 15 February 2006

Mercredi 15 février 2006

*The committee met at 1003 in committee room 1.*LOCAL HEALTH SYSTEM
INTEGRATION ACT, 2006LOI DE 2006 SUR L'INTÉGRATION
DU SYSTÈME DE SANTÉ LOCAL

Consideration of Bill 36, An Act to provide for the integration of the local system for the delivery of health services / Projet de loi 36, Loi prévoyant l'intégration du système local de prestation des services de santé.

Mr. Mario G. Racco (Thornhill): Good morning. I think we do have a quorum. Just so we can deal with all the issues today, which is expected to be the last day, we should try to start, unless there is any disagreement from anybody. Therefore, good morning and welcome to the last day on Bill 36.

Yesterday, we left off at page 82. I would go to Mr. Arnott. I believe that's your motion. Sir, would you like to start?

Mr. Ted Arnott (Waterloo-Wellington): Mr. Chairman, I am withdrawing that motion.

The Chair: We seem to be starting very fast this morning. So the motion on page 82 is withdrawn.

We move to page 83. It is from the government side. Mr. Ramal, or anyone?

Mr. Khalil Ramal (London-Fanshawe): Give me a second.

The Chair: Yes. That's no problem. We have lots of members of staff available if there are any questions, I understand. On my right side?

Mr. Arnott: Mr. Chair, if I might *[inaudible]*. I understand that yesterday, the Minister of Health, in a scum, indicated that the opposition parties were filibustering this bill in committee. I was very disappointed to hear him say that. When hearing that from the minister, one immediately thinks that when we're not filibustering, perhaps we should show him what a filibuster is. But certainly that's not my intention today, as I indicated by my withdrawal of the first motion.

The Chair: And I appreciate that.

Mr. Arnott: I look forward to the minister's clarification when he publicly tells the press that he was wrong.

The Chair: Thank you, Mr. Arnott. I'm sure that Ms. Wynne did hear your comments, and it's her responsibility, I would suggest, to inform the minister and all

his staff here, and it's up to the minister to make the decision. We are dealing with clause-by-clause, but I appreciate your comments.

We are at page 83, Ms. Wynne, if you are ready. By the way, the motion on page 82 has been removed, so we are at page 83.

Ms. Kathleen O. Wynne (Don Valley West): I move that subsection 25(4) of the bill be struck out and the following substituted:

"Parties to decision

"(4) The following persons and entities are parties to an integration decision issued by a local health integration network:

"1. If the decision is issued under clause 25(2)(a), the parties to the agreement that the network facilitates or negotiates under that clause.

"2. If the decision is issued under clause 25(2)(b) or (c), the health service provider to which the decision is issued."

This amendment would clarify the intent of the legislation by being more explicit about the parties to an integration decision.

The Chair: Is there any debate on the motion? If there is none, I will put the question. Those in favour of the amendment? Those opposed? The amendment carries.

Mr. Arnott, page 84.

Mr. Arnott: I move that subsection 25(5) of the bill be amended by adding the following clause:

"(c.1) a requirement that the parties to the decision develop a human resources adjustment plan in respect of the integration;"

I'm advised that this was recommended by the Brewery, General and Professional Workers' Union. This is a requirement of all parties involved in the restructuring plan to participate in efforts to reach an agreement on a human resources plan. This was an element of the Conservative Health Services Restructuring Commission process that was helpful in reducing the adverse impact of transition. The plans address issues such as how employees in the donor hospital secure positions in the recipient hospital and how to deal with inconsistent terms and conditions of employment.

The Chair: Thank you for the explanation. Is there any debate? Ms. Wynne.

Ms. Wynne: No, just that I'll be supporting this amendment. We had put the same one in.

The Chair: Any further debate? If there's none, I will now put the question. Those in favour? It carries.

The next motion is from Ms. Wynne, page 85.

Ms. Wynne: I will withdraw this motion because it's identical to the previous one.

The Chair: Thank you.

Mr. Arnott, page 86.

Mr. Arnott: I move that section 25 of the bill be amended by adding the following subsection:

"Appeal

"(11) A party to an integration decision or a member of a community affected by an integration decision may appeal the decision by following the prescribed process."

The Chair: Any explanation or any debate? If there is none, I will now put the question. Those in favour? Those opposed? It does not carry.

We have dealt with all the amendments, and therefore I will take a vote on the section. Shall section 25, as amended, carry? Those in favour? Those opposed? The section carries.

Section 26, Ms. Wynne, page 87.

Ms. Wynne: I move that subsection 26(1) of the bill be amended by striking out "subsections (2) to (4)" in the portion before paragraph 1 and substituting "subsections (2) to (6)."

This is a technical amendment to reflect other amendments that have been made.

The Chair: Any debate? If there is none, I'll put the question. Those in favour? Those opposed? It carries.

Mr. Arnott, page 88.

Mr. Arnott: I move that section 26 of the bill be amended by adding the following subsection:

"Date

"(1.1) The date mentioned in subsection (1) shall not be earlier than six months from the day that the local health integration network makes the decision."

If I may, I understand this amendment was requested by the Canadian Hearing Society. Apparently, this legislation contains no mention of transition planning and timelines. When an integration decision is made, it will have a ripple effect on staffing, leases, legal and other wind-down or expansion considerations of affected health service providers. This amendment that we're putting forward allows for a six-month minimum transition period so that affected providers can plan for the ordered integration and thereby minimize service disruption.

1010

The Chair: Any debate? Ms. Wynne.

Ms. Wynne: I won't be supporting this motion. We actually heard during the hearings that there were groups that wanted to make sure that we didn't set up barriers to integration. This is an arbitrary time period and so it's not necessary.

The Chair: Any further debate? If there's no more, I will now put the question. Anyone in favour? Anyone opposed? Does not carry.

Mr. Arnott, page 89.

Mr. Arnott: Mr. Chairman, I'm withdrawing the amendment.

The Chair: Thank you. Page 90, Mr. Arnott.

Mr. Arnott: I move that clause 26(2)(f) of the bill be amended by adding "as determined under section 1 of the Canadian Charter of Rights and Freedoms" after "unjustifiably."

If I may, Mr. Chairman—I understand this was requested by the Catholic Health Association of Ontario and St. Joseph's Healthcare and Hamilton health services. As written, "unjustifiably" is not defined in this bill, and therefore this clause does not provide sufficient protection for denominational rights. This provision respects and protects the denominational nature of a health service provider that is a religious organization, including the members of the Catholic Health Association of Ontario. It's our contention that the wording "unjustifiably" is too loose and that the additional wording would make it clear. As intended by the ministry, the word "unjustifiably" has the careful meaning ascribed to it by section 1 of the Canadian Charter of Rights and Freedoms.

The Chair: Any debate on the motion? If there's none, I'll put the question. Those in favour of the motion? It carries.

Ms. Wynne, 91.

Ms. Wynne: I'd like to withdraw 91. It's identical to the motion we just passed.

The Chair: Thank you. Mr. Arnott, page 92.

Mr. Arnott: I move that subsection 26(2) of the bill be amended by adding the following clause:

"(f.1) shall not interfere with the provision of services of pastoral care or religious or spiritual care and ethics by a health service provider that is a religious organization."

Again, I understand, Mr. Chairman, that this was requested by the Catholic Health Association of Ontario.

The Chair: Any debate? If there's none, then I'll—

Ms. Wynne: Mr. Chair, just to be clear that I won't be supporting this because it's unclear what this adds to the protections that are already in the legislation.

The Chair: Any further debate? If there's none, I'll put the question. Those in favour of the amendment? Opposed? It does not carry.

Madam Martel, page 92a, please.

Ms. Shelley Martel (Nickel Belt): I move that subsection 26(3) of the bill be amended by striking out "a health service provider that is."

This section is a request for reconsideration. Right now it says that a health service provider that is a party to the decision may request the LHIN to reconsider it. It's my view and it was the view of many who made submissions that there's more of an interest than just the health service provider—the clients of that health service provider that would potentially be affected negatively, who should have a right to reconsideration, as well as a union if they are actually in the workplace and providing services for that health service provider. The deletion of "health service provider" would allow for a broader opportunity of parties generally to ask for reconsideration.

ation. The parties, obviously, would be clients and a trade union if they are in a workplace.

The Chair: Thank you. Ms. Wynne?

Ms. Wynne: Chair, I won't be supporting this. What this would do is it would make it so that anybody could request a reconsideration, and my contention is, that would be too broad.

The Chair: Any further debate?

Ms. Martel: I'm wondering, given that right now it's very restrictive—right now only the health service provider can actually request a reconsideration, so those clients who are affected as this now stands don't have an opportunity. I think they should, and I also think that the trade union, if their jobs are going to be lost, potentially should have an opportunity. My concern is that it is restrictive at this point and it's a very narrow definition of who can actually apply for reconsideration when there are much broader implications for some of these decisions.

Ms. Wynne: I'll just make one comment, and that is that the opportunity for public engagement in the planning process is up front as opposed to at this point in the process. So we've tried to set it up so that there would be a broad public engagement initially.

Ms. Martel: But that's different from a decision. There are some mechanisms for people to plan. We're talking about a LHIN actually making a specific decision and who has a right to respond. The public engagement process—people would not be aware of what decisions are going to be made, so that's not an opportunity for them to respond. If a decision is made, there should be an opportunity at that point. They can't make those judgments in a broad consultation process. They don't know what the LHIN's going to do. So I don't see a broader consultation process as really the mechanism to deal with very specific decisions and how one can deal with those.

The Chair: Any further debate? If there's none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Madam Martel, 92b, please.

Ms. Martel: I move that subsection 26(5) of the bill be struck out and the following substituted:

"Further reconsideration

"(5) If a local health integration network amends or revokes a decision under clause (4)(b), a party to the decision may request that the local health integration network reconsider its decision under clause"—

Ms. Wynne: Sorry, are we doing 92b or 92c, Ms. Martel?

The Chair: It should be 92b in front of us. If you're reading 92c—

Ms. Wynne: She was reading 92c.

Ms. Martel: My apologies, Mr. Chair.

I move that subsection 26(4) of the bill be amended by striking out "health service provider" in the portion before clause (a) and substituting "party."

This is the same argument as before. This is with respect to an appeal.

I know the government has some amendments that are coming up, and so do the Conservatives, about revising

this whole section with a new reconsideration. The government amendments talk about making copies of the proposed decision available to the public and any person may make a written submission about the proposed decision. I could be wrong about this, but it seems to me that that's pretty broad. If you're allowing any person to make a written submission, then that seems to be any party being able to make a submission as well. So I'd ask the government to look at this again.

We just voted down an amendment that would have allowed anybody to appeal, but if I read the government amendments, allowing any person to make a submission would essentially have the same effect. I'm not sure why the government would have voted the other amendment down, given what's coming.

Ms. Wynne: Maybe we can get some advice from staff here about what the difference is.

The Chair: Maybe you can stay there for the rest of the day, if you don't mind, please.

Ms. Tracey Mill: Government motion 94 would amend the reconsideration process that's in the bill and would require public notice and would permit submissions from any parties that might be affected. So it isn't restricted just to the health service provider.

Mr. Robert Maisey: My name is Robert Maisey, counsel, Ministry of Health and Long-Term Care. If I could just add a clarification to that, it's any "person." It's not a "party" to the decision, because there has been an amendment to section 25(4) that clarifies who a party to the decision is. So the proposed government motion 94, subsection 26(4), would allow any person to make a written submission.

The Chair: Mr. Wood, do you have an explanation?

Mr. Michael Wood: Yes. Michael Wood, legislative counsel. One other point to consider in this is that subsections (3) and (4), as presently written, contemplate that people will be asking the LHIN to reconsider a decision once it has been made, whereas the government motion to rewrite subsections (3) through (5) introduces a different concept—that is, that parties get a right to make submissions before the decision is actually made and that there is a notice given of the proposed decision and the public has the right to comment on that.

Ms. Martel: But if you've changed the definition of "party" earlier on, how does that impact here then? Are you trying to say, because you've used "persons" instead of "parties," that broadens it?

In the amendment that I was moving, which was to try and broaden those who could be implicated, because of the change in definition of "party" that the government passed, it would now make my limiting motion a restrictive one?

1020

Mr. Maisey: It would have no effect. Motion 92b would not extend it to anyone other than a person who was a party, and the definition of "party" has already been amended to—

Ms. Martel: That's what I mean. As a consequence of the government change in the definition of "party,"

which wasn't my reference to "party," this now becomes restrictive, only because it is tied to the definition of "party" that the government has passed in a previous amendment.

Mr. Maisey: I wouldn't say it's restrictive, because the intent of the definition of who a "party" was, was always that it would be the health service provider.

Ms. Martel: But I want that to be broader, and I'm assuming the government wants that to be broader too.

Mr. Maisey: That's right. How I would say it is that the intent of your 92b would not be achieved now.

Ms. Martel: I get it.

The Chair: Any further debate?

Ms. Martel: No. In view of the change in definition that now impacts this one, I'm going to withdraw this amendment.

Interjection.

Ms. Martel: No, now it's 92c. Sorry. This is the one I was doing before.

I move that subsection 26(5) of the bill be struck out and the following substituted:

"Further reconsideration

"(5) If a local health integration network amends or revokes a decision under clause (4)(b), a party to the decision may request that the local health integration network reconsider its decision under clause (4)(b) and subsection (3) applies for that purpose.

"Same

"(6) If a party requests a reconsideration under subsection (5), the local health integration network may reconsider that decision if, in its opinion, there are compelling reasons to do so."

This would apply for a second request for reconsideration, particularly in the case where there has been a request for reconsideration; there has been an amendment to an original decision that was made by the LHIN. This would give the parties, broadly speaking—"persons" is probably the better word—an opportunity also to deal with the amendment in the case that they find the amendment also to be unsatisfactory. So it applies a second effort at reconsideration, where the current legislation only provides for one request.

The Chair: Any debate on this?

Ms. Wynne: In light of the conversation you just had, Ms. Martel, our motion 94 is similar, but yours includes a longer time period and doesn't include public notice. I'm just wondering if 94—do you want to get staff to talk about the difference between the two? Could we get a distinction made between these two? I apologize.

Ms. Martel: As I understand 94, the decision has actually been formerly rendered. What the LHIN is proposing is actually transmitted to parties or bodies and then there can be a response. I'm making a request for specifically after a decision has been made.

Ms. Mill: That's correct. Government motion 94 would set up a process where the LHIN would have to give notice of an intended decision before actually issuing the decision. There's a 30-day time period where any interested person could make submissions about that

proposed decision. The LHIN would consider that and then they would make their final decision. That would replace the current provisions in the statute that deal with a reconsideration process. As I understand it, your motion 92c would include a reconsideration when the LHIN was either amending or revoking a final decision, so this would put another review or reconsideration process into that process.

Ms. Wynne: From our perspective, that would protract the process.

Ms. Mill: It would extend the process and review of the decisions beyond what is being proposed in government motion 94. Government motion 94 would have the discussions taking place before a final decision was actually made.

Ms. Wynne: That makes it clear for me. I won't be supporting 92c.

The Chair: Any further debate? I will now put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

We go to Mr. Arnott, 93a.

Mr. Arnott: I'm withdrawing that motion, Mr. Chair.

The Chair: Thank you—very efficient.

Ms. Wynne, 94, please.

Ms. Wynne: I move that subsections 26(3) to (5) of the bill be struck and the following substituted:

"Notice of proposed decision

"(3) At least 30 days before issuing a decision under subsection (1), a local health integration network shall,

"(a) notify a health service provider that the network proposes to issue a decision under that subsection;

"(b) provide a copy of the proposed decision to the service provider; and

"(c) make copies of the proposed decision available to the public.

"Submissions

"(4) Any person may make written submissions about the proposed decision to the local health integration network no later than 30 days after the network makes copies of the proposed decision available to the public.

"Issuing a decision

"(5) If at least 30 days have passed since the local health integration network gave the notice mentioned in subsection (3) and after the network has considered any written submissions made under subsection (4), the network may issue an integration decision under subsection (1), and subsections (3) and (4) do not apply to the issuance of the decision.

"Variance

"(6) An integration decision mentioned in subsection (5) may be different from the proposed decision that was the subject of the notice mentioned in subsection (3)."

I think we've talked about what this amendment would do, allowing an up-front process before a decision was made.

The Chair: Any debate? If not, I shall put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Mr. Arnott, page 95.

Mr. Arnott: I withdraw that motion, Mr. Chair.

The Chair: Thank you. And 96?

Mr. Arnott: I withdraw that motion as well.

The Chair: Thank you. Therefore, we'll now take a vote on the section. Shall 26, as amended, carry? Those in favour? Those opposed? The section carries.

Section 27. Mr. Arnott, motion 97.

Mr. Arnott: I withdraw that motion.

The Chair: Thank you.

Ms. Wynne, motion 98a.

Ms. Wynne: Mr. Chair, we have 97a, b and c.

The Chair: Oh, I'm sorry. I was going to deal with them later on. Therefore, Madam Martel, please.

Ms. Martel: I move that subsection 27(6) of the bill be amended by striking out "a health service provider that is."

I'm assuming this is going to be the same, because "party" has now—oh, wait a minute. It's not. Because "party" has been defined, this is the same issue as before with respect to different decisions. I withdraw it, then.

The Chair: You withdraw this one. How about 97b?

Ms. Martel: That would be the same. I will withdraw.

The Chair: And 97c?

Ms. Martel: I had a question about this one. We have made a change with respect to 94, the government motion that is applicable to proposed decisions. I gather that only applies in that particular section and does not apply to any of section 27, the integration by health service providers?

Ms. Mill: Government motion 98 would basically create the same type of process as we just spoke about. In government motion 98, it would require the LHIN to provide advanced notice of—sorry. It would first require the health service provider who was going to integrate to give notice to the LHIN. Then the LHIN, if they were going to consider objecting to that integration, would have to give notice that they were intending to do that; there would have to be public notice of that. There is an opportunity for submissions to be made by the health service provider to the LHIN before the LHIN issuing a final decision about whether to stop the integration or not.

Ms. Martel: So what mine would do is the same as before, which was to have a further reconsideration, which was already voted down. It would be voted down again, so I'll withdraw it.

The Chair: Okay. Back to you, Ms. Wynne.

1030

Ms. Wynne: I move that subsections 27(3) to (8) of the bill be struck and the following substituted:

"Notice to network

"(3) If the integration mentioned in subsection (1) relates to services that are funded, in whole or in part, by a local health integration network, the health service provider,

"(a) shall give notice of the integration to the network, unless the regulations made under this act prescribe otherwise;

"(b) may proceed with the integration if the service provider is not required to give the notice mentioned in clause (a);

"(c) shall not proceed with the integration until 60 days have passed since giving the notice mentioned in clause (a), if the service provider is required to give the notice and the network does not give notice under subsection (4);

"(d) shall not proceed with the integration until 60 days have passed since the network gives notice under subsection (4), if,

"(i) the service provider is required to give notice under clause (a),

"(ii) the network gives notice under that subsection, and

"(iii) the network does not issue a decision under subsection (6); and

"(e) shall not proceed with the integration that is the subject of a decision under subsection (6), if the network issues such a decision.

"Notice of proposed decision

"(4) No later than 60 days after the health service provider gives the notice required under subsection (3), the local health integration network may,

"(a) notify a health service provider that the network proposes to issue a decision under subsection (6);

"(b) provide a copy of the proposed decision to the service provider; and

"(c) make copies of the proposed decision available to the public.

"Submissions

"(5) Any person may make written submissions about the proposed decision to the local health integration network no later than 30 days after the network makes copies of the proposed decision available to the public.

"Issuing a decision

"(6) If more than 30 days, but no more than 60 days, have passed after the local health integration network gives notice under subsection (4) and after the network has considered any written submissions made under subsection (5), the network may, if it considers it in the public interest to do so, issue a decision ordering the health service provider not to proceed with the integration mentioned in the notice under clause (3)(a) or a part of the integration.

"Matters to consider

"(7) In issuing a decision under subsection (6), a local health integration network shall consider the extent to which the integration is not consistent with the network's integrated health service plan and any other matter that the network considers relevant.

"Variance

"(8) An integration decision mentioned in subsection (6) may be different from the proposed decision that was the subject of the notice given under subsection (4)."

We had a conversation about this motion, which replaces the reconsideration process that's in the bill and puts a process in place that allows for notice and a draft decision process prior to the final decision.

The Chair: Is there any debate? If there is no further debate, I will now put the question. Those in favour? Those opposed? It carries.

Mr. Arnott, page 99.

Mr. Arnott: I withdraw that motion

The Chair: Page 100?

Mr. Arnott: I withdraw that motion.

The Chair: Thank you.

There has been an amendment. Therefore, shall section 27, as amended, carry? Those in favour? Those opposed? It carries.

Section 28. Madam Martel, page 101.

Ms. Martel: I just want to make some comments about why we're recommending voting against this section entirely. There were two points of view about this section during the course of the public hearings. There was a view that was expressed, for example, by OANHSS, which is the association that represents not-for-profit long-term-care homes and service providers. They appeared on the second day and said that from their point of view, this section permitted discrimination because it allowed the minister to make recommendations, order a ceasing of operations, amalgamation etc., that impacted only on not-for-profit organizations, and there was no similar responsibility or power that the minister had with respect to for-profits. So there were a number of groups who came before the committee and said that the government should do one of two things: either apply the ministerial power to for-profit organizations as well or delete the section altogether.

The most persuasive argument I heard with respect to this section was in a presentation—actually, in a question and answer period that came after a presentation that was made jointly by CAMH, the federation of mental health and addiction services and a third provider that represents essentially survivors, those consumer support/consumer survivor initiatives. In the questioning after, the representative from CAMH, who is a vice-president at CAMH, told the committee that she had, in a previous life, done drafting of legislation at the Ministry of Health, and from her perspective, after having done that, the changes that were in this bill, particularly in this section, gave incredible power to the minister, more than she had ever seen. Her recommendation, very strongly, was that the entire section be deleted because of the extraordinary power that it gave to the minister to have operations cease, to dissolve, to wind up operations, to force amalgamations etc.

I am not persuaded by some of the amendments that will come from the government, where there is some attempt to clarify certain things, that the way to go is to apply this section to both not-for-profits and for-profits. I think this section altogether is unacceptable because of the extraordinary new powers that it grants unilaterally to the Minister of Health. That is why the NDP recommends voting against this entire section. We should not be giving the Minister of Health these kinds of powers to make these kinds of decisions.

The Chair: Is there any debate?

Ms. Wynne: Just to say that we are going to be bringing forward amendments. We did hear the concerns about this section, and we'll be amending it.

Ms. Martel: Chair, if I might, if I look at the government amendments—I'm looking at 103 and 104—I see that the government response, at least in 103, is to apply these excessive ministerial powers equally to the for-profit and not-for-profit sectors. That's my read of it.

There's a section on 104—paragraph 4 is a little difficult for me to understand. My question is whether or not it will really stop a transfer of not-for-profit operations to for-profit operations. Regardless of that, even if it does, the provisions that the minister has to force providers to cease operating, to dissolve or to wind up, to amalgamate or to transfer all of their operations to one person or another continue to exist. Those excessive powers by the government have not been dealt with. There is no change in those excessive powers. Many groups came forward and said that it wasn't just a question of this being applied only to the for-profit sector; their concern was the extreme powers that had now been granted to the minister. That's why we'll be voting against this section, because that has not been changed; that has not been fixed.

The Chair: Maybe we should introduce the section—

Ms. Wynne: Could I just make a brief comment? First of all, some of the powers in this section are powers that already reside with the minister and have done so since the previous government. The second point is that the issue that was raised by many of the people who came before us was the inconsistency of treatment, particularly in the long-term care sector. That's why we're amending this section.

The Chair: Can I have Ms. Wynne deal with 103, please?

Ms. Wynne: Okay. So we don't need to do anything with 101 or 102?

The Chair: No, 101 and 102 are not motions.

Ms. Martel: We can't vote against that section?

The Chair: No, at the end of the section. We're going to deal with all of the amendments.

Ms. Wynne: Yes, you recommended that.

The Chair: Your comments would have made more sense at the end of the day, but that's fine; you made them.

Go ahead, please.

Ms. Wynne: I move that subsection 28(1) of the bill be amended by striking out "on a not-for-profit basis to do any of the following on or before" in the portion before paragraph 1 and substituting "on a for-profit or not-for-profit basis to do any of the following on or after."

The Chair: Is there any debate on this?

Mr. Arnott: I'd like to hear an explanation from the government side as to what this amendment does.

Ms. Wynne: This addresses the inconsistency that presenters raised with us during the hearings. It means that health service providers who operate on a for-profit or a not-for-profit basis may be the subject of a minister's integration order. This attempts to address the issue

around long-term care homes about the differential treatment of long-term care providers that are not-for-profit and for-profit.

The Chair: Any other comments? If there is no more debate, then I now put the question. Shall the motion carry? Those in favour?

Ms. Martel: Recorded vote.

Ayes

Matthews, Ramal, Sandals, Wynne.

Nays

Arnott, Martel.

The Chair: The amendment carries.

Page 104, Ms. Wynne.

Ms. Wynne: I move that paragraphs 2, 3 and 4 of subsection 28(1) of the bill be struck out and the following substituted:

“2. To amalgamate with one or more health service providers that receive funding from a local health integration network under subsection 19(1).

“3. To transfer all or substantially all of its operations to one or more persons or entities.

“4. To do anything or refrain from doing anything necessary for the health service provider to achieve anything under any of paragraphs 1 to 3, including to transfer property to or to receive property from another person or entity in respect of the operations affected by the order.”

1040

The Chair: Any debate?

Ms. Martel: I'd like to be clear that for paragraph 1, ministerial power—which as it now stands: “1. To cease operating, to dissolve or to wind up its operations”—remains intact, so that is still a power that the minister has. Secondly, the changes still give the minister the power to amalgamate one or more service providers that receive public funding and it still gives the minister the power to transfer all or substantially all of its operations to one or more persons or entities, so all the powers that people defined as being excessive still remain. There's been no change in that regard. Those powers continue to be held by the minister, to be used by the minister at his discretion.

Ms. Mill: Your characterization of paragraphs 1, 2 and 3 are correct. In paragraph 4, the change from what is in the bill is actually just to pick up consistency in wording in the bill that is used in the LHIN integration section. There's no substantive change there. It's just a wording change to have internal consistency in the bill with respect to that clause.

Ms. Martel: So to be clear, there'd be nothing in here, and I think that this is the case—what has been done in basically the two amendments, or probably the one before, is that the minister's ability to do things will now

be applied equally to the not-for-profit and the for-profit sector. That's the first question.

Ms. Mill: There are some limitations introduced in a further government motion, number—

Mr. Maisey: It's number 108. Government motion 108 sets out some limitations.

Ms. Martel: Are they limitations on his power in terms of ceasing operations, dissolving, amalgamating, transferring?

Mr. Maisey: Yes, they are. Sorry, I'm jumping ahead now into explaining that government motion. Is that appropriate or should we wait?

Ms. Wynne: Actually, can we just deal with 108? The issue of long-term care is going to come up, so if we deal with it now in the context of this clause, I think it'll clarify it later.

The Chair: That's fine with me, unless there is an objection. Go ahead.

Mr. Arnott: I'm quite concerned about these government amendments 103, 104 and 108, which appear to give the Minister of Health extraordinary arbitrary power to shut down health service providers, including non-profit businesses as well as for-profit businesses. We have put forward additional amendments to section 31. I hope the government will give consideration to supporting those to ensure that people's interests are protected. I want to express my reservations and my definite opposition to these three amendments that the government has put forward: 103, 104 and 108.

The Chair: You can go ahead now and give us the explanation.

Mr. Maisey: Certainly. With respect to government motion number 108, let me deal with the two large issues first in paragraphs (d) and (e). Paragraph (d) would prevent the amalgamation of not-for-profit organizations into for-profit organizations. Paragraph (e) is a companion to that to prevent the transfer of operations of a not-for-profit organization into a for-profit organization. Those are in paragraphs (a), (b) and (c). Paragraph (a) deals with municipal homes for the aged. It also deals with municipalities. In other words, the minister could not use powers under section 28 in respect of municipal homes for the aged or municipal governments.

Ms. Martel: Because they're funded by the municipalities?

Mr. Maisey: Because they're funded by the municipalities, because they're not-for-profit homes and because municipalities are required under the Homes for the Aged and Rest Homes Act to operate a municipal home. It's clarifying how this section 28 applies.

Also, in respect of a municipality, obviously the Minister of Health would never use powers to amalgamate municipalities under this statute. Amalgamations of municipalities are dealt with under the Municipal Act.

Ms. Martel: I don't think anybody suggested that during the course of the hearings, though.

Mr. Maisey: I thought the Association of Municipalities of Ontario had raised a concern about that.

Ms. Martel: I didn't think it was amalgamating municipalities, though. Maybe I didn't read their brief entirely. Sorry, my apologies.

Ms. Wynne: What amendment 108 will do is address the concerns about long-term care being included in this section, and it addresses the issue of moving from a not-for-profit to a for-profit, amalgamation of a not-for-profit into a for-profit. That was something that was raised over and over by people who came before us, so I would think that there would be a lot of support for this amendment.

Ms. Martel: If I go back, to me, there were two points that were raised through this whole context: either you could apply the sections equally or you could strike it out altogether if your concern was with the enormous power of the minister. When I gave my reasoning for voting against it, it was for that reason, that on the face of it, in listening to the arguments, while I remain very concerned about the potential loss of for-profits, my overwhelming concern in this whole section has been the new powers that have been given to the minister. I think that was made clear to us not only in the presentation by CAMH, where the vice-president made it clear she had worked for the Ministry of Health and had drafted legislation, and this language gave the minister more power than she had ever seen, we also heard a similar sentiment being expressed by the physiotherapy association, which also said that this was above and beyond even the previous government's Health Services Restructuring Commission. My concerns continue because of the new powers that I feel, and that I think have been confirmed for us during the course of the public hearings, have now been granted to the minister. I know staff can't do anything about that.

Ms. Wynne: Can I just make a comment, and then we'll leave this?

Interjection.

Ms. Wynne: I understand. We have to get going. But just to be clear, the legislation as it's written doesn't grant new powers to the minister; the powers already exist. What it does do is put process in place around those powers and specify how those powers can be exercised. The powers that are in place currently are left over from a previous government. What we're trying to do is put some guidelines around them and put process in place. Yes, the minister is going to have some authority to facilitate amalgamations and integrate the system.

Ms. Martel: If I might, and I'll conclude: We're going to have to agree to disagree on this. We heard two presentations where folks—one in particular, who I think would know very well—gave a completely different opinion. The vice-president from CAMH was very clear that in a previous role in the ministry, her read of the language now is that this does give more powers to the minister. We heard that repeated in a presentation by the physiotherapy association, and we have seen that repeated in at least three of the legal opinions that have been done, which have probably not been shared widely with the committee, but certainly that I've had access to and others have had access to as well. We clearly have a

difference of opinion about whether or not these are the same powers and whether or not they're more. My argument is that they are more, and that's why we'd be voting against this section.

The Chair: It's everybody's opinion, and that's fair; I think we heard them. I will recognize Mr. Ramal, and then if we can move on, please.

Mr. Ramal: Just a question to staff: This bill will give the Minister of Health more power than he has right now at the present time or just facilitate power among the 14 LHINs?

Ms. Mill: The minister currently has powers to carry out some of these functions in some statutes and for some sectors; in other sectors, this would be some additional authority for the minister. It is correct to say too that in those sectors where he has that authority already, this puts some additional process into that.

The Chair: Thank you. Mr. Arnott, please.

Mr. Arnott: Just to conclude briefly, we've just heard staff reinforce why the opposition is concerned about this. New powers are being granted to the minister, and we're concerned about the potentially arbitrary use of them to negatively impact on health care in Ontario. So I'm going to continue to vote against these amendments.

The Chair: Any further debate? If there is no further debate, then I will put the question. Shall the motion carry? Those in favour?

Ms. Wynne: We're voting on 103.

The Chair: No, 104. We dealt with 103; it's 104 we're dealing with. That's the only one on the floor.

Shall the motion carry? Those in favour?

Mr. Arnott: Recorded vote.

Ayes

Matthews, Ramal, Sandals, Wynne.

Nays

Arnott, Martel.

The Chair: Page 105, Mr. Arnott, please.
1050

Mr. Arnott: I move that subsection 28(2) of the bill be amended by adding "as determined under section 1 of the Canadian Charter of Rights and Freedoms" after "unjustifiably."

The reason for this amendment being proposed today is because it was requested by the Catholic Health Association of Ontario and St. Joseph's Healthcare and Hamilton Health Sciences. As written, "unjustifiably" is not defined in this bill, and therefore this clause does not provide sufficient protection for denominational rights. Therefore, we are moving this amendment to clarify that.

The Chair: Any debate on the motion? If there's no debate, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Ms. Wynne: Mr. Chair, I'd like to withdraw 106.

The Chair: It will be withdrawn.

We go to 107. Mr. Arnott, back to you.

Mr. Arnott: We are prepared to withdraw this.

The Chair: Number 107 is also withdrawn. Number 108, Ms. Wynne.

Ms. Wynne: I move that section 28 of the bill be amended by adding the following subsection:

“Restrictions

“(2.1) Despite subsection (1), the minister shall not,

“(a) issue an order under that subsection to a board of management described in paragraph 5 of the definition of ‘health service provider’ in subsection 2(2) or a municipality;

“(b) issue an order under that subsection to a health service provider described in paragraph 4 or 6 of the definition of ‘health service provider’ in subsection 2(2), if the service provider is not also described in another paragraph of that definition;

“(c) issue an order under paragraph 1 of that subsection, in respect of the operation of a nursing home or charitable home for the aged, to a health service provider described in paragraph 4 or 6 of the definition of ‘health service provider’ in subsection 2(2), if the service provider is also described in another paragraph of that definition in respect of the home;

“(d) issue an order under paragraph 2 of that subsection to a health service provider that carries on operations on a not-for-profit basis to amalgamate with one or more health service providers that carries on operations on a for-profit basis; or

“(e) issue an order under paragraph 3 of that subsection to a health service provider that carries on operations on a not-for-profit basis to transfer all or substantially all of its operations to one or more persons or entities that carries on operations on a for-profit basis.”

I think we’ve had a long discussion about this amendment.

Mr. Ramal: Can we have a recorded vote?

The Chair: Yes. Let’s see if there’s any debate on this.

Ms. Martel: I’m going to repeat my concern about the ministerial power in this entire section, which from my perspective is new and unprecedented, and repeat my concern that the whole section in fact should be taken out. The minister should not have these kinds of powers. I’m voting against the entire section.

The Chair: Any further debate?

Mr. Arnott: Just to reiterate, the position of the Progressive Conservative Party is to have section 28 in its entirety deleted. As such, I cannot support this government motion.

The Chair: Any further debate? If there’s none, I shall put the question.

Ayes

Matthews, Ramal, Sandals, Wynne.

Nays

Arnott, Martel.

The Chair: The motion carries.

Mr. Arnott, 109.

Mr. Arnott: I’m prepared to withdraw the proposed amendment.

The Chair: Thank you. Ms. Wynne, 110.

Ms. Wynne: I move that subsection 28(3) of the bill be amended by striking out “and 26(3) to (5)” and substituting “clauses 26(2)(g) and (h) and subsections 26(3) to (6).”

This is a technical amendment that would add a new reference that would restrict the minister from transferring charitable property to a person or entity that is not a charity.

The Chair: Any debate? If there’s none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? Carried.

There have been five amendments approved. Therefore, shall section 28, as amended, carry?

Ms. Martel: Recorded vote.

Ayes

Matthews, Ramal, Sandals, Wynne.

Nays

Arnott, Martel.

The Chair: It does carry.

Section 29: Ms. Wynne, 111.

Ms. Wynne: I move that subsection 29(3) of the bill be amended by striking out “after the point in time specified in subsection (4).”

This amendment removes reference to subsection 29(4) because there is a proposed amendment, which is 112, to repeal that provision.

The Chair: Any comments? If none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Page 112, Ms. Wynne.

Ms. Wynne: I move that subsection 29(4) of the bill be struck out.

This removes the reference to the time limits for filing an application for a court order, and 29(4) would no longer be necessary if the amendment to replace the reconsideration process with a notice provision were adopted, which is motion 98.

The Chair: Any debate? I shall put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Shall section 29, as amended, carry? Those in favour? Those opposed? It carries.

Section 30: Mr. Arnott, 113.

Mr. Arnott: Our party is recommending that we vote against section 30 in its entirety. So I would ask that members consider voting against it. The reason is that our party is in agreement with the Association of Fundraising Professionals and the Association for Healthcare Philanthropy, that giving the minister or the LHIN authority to order a transfer of charitable property is

unprecedented and fraught with complications. The provision is unnecessary because the courts already have justification to transfer charitable property under the cypres doctrine, I am told. The courts are a better place than the LHINs or the minister to make decisions regarding transfer of charitable property. The courts are impartial, transparent and have expertise and experience in making such decisions. It is unclear how the minister or the LHIN will be able to break the legally binding contract, as most gifts are, between the donor and the recipient health care provider. Donors and health service providers have no apparent input regarding the transfer. Forced transfers fail to take into account the intent and wishes of the donors when they make the donation. If donors feel they are losing their voice over the use of their gifts, then vital charitable assets will be removed from the overall health care system.

That is our concern, and it is supported by the Association of Fundraising Professionals and, again, the Association for Healthcare Philanthropy. Therefore, I would encourage all members of this committee to vote against section 30.

The Chair: Ms. Wynne, 114, please.

Ms. Wynne: I just wanted to comment that—

The Chair: We can do it at the end of the section, please. I am going to enforce that from now on.

Ms. Wynne: Okay, yes—114?

The Chair: Yes.

Ms. Wynne: I move that the English version of subsection 30(1) of the bill be amended by striking out “property of the transferee” at the end and substituting “property to the transferee.”

This is a drafting error correction.

The Chair: Any comments?

Mr. Arnott: I'd just like to ask the staff what, exactly, this means. I would like a staff explanation.

The Chair: Could staff explain, please.

Ms. Wynne: All it means is that the property goes to the transferee.

The Chair: Okay. Do you want staff—Ted?

Mr. Arnott: I'd like the staff to confirm that.

Ms. Wynne: Sure.

Ms. Paula Kashul: I'm Paula Kashul, counsel with the Ministry of Health and Long-Term Care. The ending of this now says—and I'll just read the last bit—“that form part of the property being transferred shall be deemed to be gifts, trusts, bequests, devises and grants of property of the transferee.”

That was an error in drafting. There is a similar provision proposed for an amendment to the CCAC Act, and in that particular section, it says “to the transferee.” So we're just correcting the word “of” here to “to” so that the property goes to the transferee.

The Chair: Thank you very much.

Any further debate? If there is no further debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Shall section 30, as amended, carry? Any comments?

Mr. Arnott: A recorded vote.

Ms. Wynne: I just wanted to make the comment that we've preserved the charitable purpose, and this allows the property to follow the service.

The Chair: Okay.

Ayes

Matthews, Ramal, Sandals, Wynne.

Nays

Arnott, Martel.

The Chair: It carries.

Section 31: Mr. Arnott, 115

1100

Mr. Arnott: I move that subsection 31(1) of the bill be amended by adding, after “takes”, “in good faith.”

This, I understand, was requested by the Ontario Long Term Care Association. This amendment will limit the ability of providers to get compensation for decisions made under this act. As written, good faith is not included and therefore cannot be made as a defence by the minister or the LHINs. Moving this amendment is, therefore, sound public policy and certainly politically expedient in the long term, but not in the short term.

“Good faith” was included in part IV of the bill but not in relation to losses arising from integration decisions. Good faith is a fundamental principle to exclude various forms of bad faith as a discretionary standard preventing parties from recapturing opportunities foregone on contracting.

For those reasons, we are supportive of this amendment.

The Chair: Is there any debate on the motion? If there is none, I will now put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Wynne, 116, please.

Ms. Wynne: I move that subsection 31(1) of the bill be amended by adding “under this act” after “a local health integration network takes.”

This change reflects the original policy intent, which is the provision that sets out that health service providers are not entitled to compensation for losses resulting from LHIN or minister direct or indirect action under this act.

The Chair: Any debate on the motion? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Mr. Arnott, 117.

Mr. Arnott: I move that subsection 31(4) of the bill be struck out.

It's my understanding that this amendment was requested by the Ontario Long Term Care Association. As written, the Expropriations Act does not apply to the bill. Deleting this section means it would. It is difficult to understand why a new process would need to be established. Ministry of Health service providers are entitled to fair compensation for the value that they have

brought into the system. The Expropriations Act is the current norm for fairness in this process.

The Chair: Any debate?

Ms. Wynne: What the bill does is propose a process for determining compensation. It's necessary to be clear that the Expropriations Act doesn't pertain, because there's another process put in place.

Mr. Arnott: And this amendment, as I understand it, would mean that the Expropriations Act would, by default, be the appropriate process.

Ms. Wynne: Yes.

The Chair: Any further debate? If there is none, I shall put the question. Shall the amendment carry? Those in favour? Those opposed? It does not carry.

We'll take a vote on the section. Shall section 31, as amended, carry? Any comments? Anyone in favour? Those opposed? It carries.

Section 32: Ms. Martel, you have three motions on this.

Ms. Martel: I move that subsection 32(3) of the bill be struck out.

This section outlines when the Public Sector Labour Relations Transition Act applies. The reference in 32(3) is actually an exception. The bill, in subsections 32(1) and (2), outlines when the act applies in terms of integrations, the changeover, who the predecessor employers are etc. Subsection (3) is an exemption so that the act does not apply in the case where the new employer or the successor employer is either a person or entity that is not a health service provider or, secondly, where the primary function of that new successor employer is not the provision of services in the health sector.

A number of trade unions that brought this to our attention said the Public Sector Labour Relations Transition Act should apply in all cases of integration. There should not be an exception to the application of the law. My concern is that what you will see here is that changes occurring would permit something like people being transferred from a hospital service to a service that is now going to be contracted out. I believe that that is the case that's being referred to here. My strong suggestion is that the act should apply to all employees who may be affected by integration orders and whose employment may be shifted, may be changed etc. The protections that they had should continue to apply.

The Chair: Any comments?

Ms. Wynne: I'll just give the rationale for not supporting this amendment. The Public Sector Labour Relations Transition Act was designed to deal with restructuring in the health sector and in other broader public sectors, and restructuring that affects a non-health-sector organization. An organization that's not functioning primarily for the health sector is dealt with under the labour relations act. So, for that reason, we need to have this section.

Ms. Martel: Can I ask a question about that in terms of the labour relations act? That gives the sense that protections that employees have would carry from one employer to successive employers and that for some of

these employees, those protections would carry under the labour relations act. Can I get a clarification of that?

Ms. Wynne: Yes, that's my understanding.

Ms. Martel: And what protections does that entail? Do successor rights, then, apply?

Ms. Mill: It may be the case that the integration would fall under the sale of business and successor right provisions of the labour relations act, section 69 of the labour relations act.

Ms. Martel: When you say it may be the case, in some cases?

Ms. Mill: It would have to meet the definition and any of the tests under the labour relations act, and any disputes or questions about that would be referred to the Ontario Labour Relations Board for a determination.

Ms. Martel: Thank you. Can you give us two cases then: one where, under this act, the ministry would presume that it would fall under the sale of business, and then employees would be protected under the labour relations act; and can you also give us a case where this might not be the case with respect to what's happening in the changes here?

Ms. Mill: I'm sorry, I don't think I would be able to do that, because it would be case-specific and, as I mentioned, in many cases, the matters would be referred to the Ontario Labour Relations Board, who would make a determination. I wouldn't have the ability to assess what they may actually find in that instance.

Ms. Martel: So what if it's not a sale? If it's an integration that's been ordered by the minister, is that considered to be a sale?

Ms. Mill: Are you referring to an integration that's been ordered under this act?

Ms. Martel: Yes.

Ms. Mill: Under this act, if the minister ordered an integration, PSLRTA would apply, except for the instances as you have been defining, where it's not a health service provider or the successor employer is not operating primarily in the health sector.

Then, again, I'd have to repeat: If it didn't meet those conditions, it is possible that the successor right provisions under the labour relations act would apply. Again, it's dependent on the circumstances.

Ms. Martel: But there's a chance that they wouldn't apply, and then those employees would have no protections, because they would have neither protection under the labour relations act nor any protection under PSLRTA.

Ms. Mill: It's case-specific.

Ms. Martel: So the way to get around it would be to make sure it does apply in one case or another, wouldn't it? You allow for an exception here, and the ministry's rationale is that they hope—I'm not trying to minimize this—that people will be covered under the labour relations act. But I don't think you can give me a guarantee that that will be the case in all areas, because we'll have to deal with this as integration orders occur, one case after the other. Would that be correct?

Ms. Mill: I think, as Ms. Wynne mentioned, the issue here or the rationale here was that the Public Sector Labour Relations Transition Act was designed for restructuring in the broader public sector, and any restructuring that is affecting employers who are not in the broader public sector are generally, as they are today, covered under other labour statutes. The processes that apply to those types of activities today are the ones that would be the result in this case also.

Ms. Martel: Thank you. If I just might make a quick comment, these amendments have been moved by both ONA and OPSEU, who would have had some experience over the past couple of years of restructuring generally, frankly, in the health sector and outside. If those two unions feel the language is not clear enough and does not provide protection—obviously they do because they've asked me to move the amendment. Because I can't get a guarantee that people will be protected in either one act or another, I would encourage the government to ensure that these exemptions are taken out; we don't have a guarantee that everyone will be covered and everybody's rights will be protected as they go through this process.

1110

The Chair: Any debate? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Motion 117b, please.

Ms. Martel: This referred to the earlier motion, and had the earlier amendment I just put passed, then this also would have needed to go into effect. I'll have to withdraw the motion because the previous amendment was voted down.

The Chair: Thank you. Motion 117c.

Ms. Martel: I move that subsections 32(6) to (21) of the bill be struck out.

This is a reference to a process under the Ontario Labour Relations Board. Under the section we just dealt with, the Public Sector Labour Relations Transition Act is to apply to integrations with the exception of the groups I was trying to get covered. It also says in 32(4) that PSLRTA would not apply if there was consent of three parties involved in the process, as I understand it: the successor employer, the previous employer and the bargaining agent or the workers themselves.

As I understand this section, if there is no agreement in subsection (4)—that is, if all three of them don't agree that PSLRTA will not apply—a party can go to the board and request that the Ontario Labour Relations Board rule that the Public Sector Labour Relations Transition Act will not apply to some of these workers. We want to get rid of that section, because my concern is that it would be a successor employer, which could well be non-union, that would be the most likely to go to the board and request that the protections under PSLRTA not apply, because then they probably wouldn't have to pay the same pay, the same benefits etc. What I'm trying to do is shut down that possibility so that there isn't an opportunity for one party to work outside the process and make an application to the board to encourage the board to rule

that PSLRTA should not apply to the workplace or the workers who are affected.

The Chair: Any debate?

Ms. Wynne: But the effect would be that well-established processes and statutes that are in place now would not pertain, so I won't be supporting this. The way the bill is written, we need to have these processes in place, and they're statutes that are used now.

Ms. Martel: If I might, this amendment was brought forward by both ONA and OPSEU. Clearly, the parties that are very likely to be affected by this bill want some guarantees that a successor employer who may well be non-union is not going to go to the board and try to make an argument against the other two parties. That's the intention of the changes from trade unions that already operate under this legislation.

The Chair: Any further debate? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 32 carry? Those in favour? Those opposed? Carried.

On section 33, the first is a notice.

We go to Ms. Wynne for 119, please.

Ms. Wynne: I move that section 33 of the bill be amended by adding the following subsection:

"Human resources adjustment plan

"(2.1) A person or entity that is required to cease performing a service described in a regulation made under subsection (1) shall develop a human resources adjustment plan in respect of the integration of the service."

This would require that public hospitals, like the University of Ottawa Heart Institute, that are integrating non-clinical services under a regulation under section 33 put in place a human resources adjustment plan. This addresses some of the concerns that we heard from unions that came forward.

The Chair: Any debate?

Ms. Martel: I'll let Ms. Wynne move both because I'm going to deal with what the union said in this regard, which was to vote against the section.

I'll raise some of the comments now. Frankly, the unions came forward and said this whole section allowed the minister to essentially contract out or privatize services that are being offered in hospitals now. That was the concern and the criticism that was raised with respect to this particular section. The section allows the Lieutenant Governor, so essentially the minister or cabinet, by regulation to order a public hospital to stop performing or to cease performing any prescribed non-clinical services and, secondly, to also integrate these services by transferring those services to another entity.

There was quite an interesting discussion on a number of occasions about this section, because the government at a certain point tried to articulate that this was being put in place because of some specific integrations that were underway, although none are named in the bill, and what is named in the bill is very broad, that the minister can order this with respect to any public hospital under the Public Hospitals Act and the University of Ottawa Heart Institute.

The second problem with this whole section is that “non-clinical services” are not defined anywhere in the bill, so we had very strong concerns raised by groups that said that on the face of it, this would probably mean, for example, cafeteria services in a hospital; secondly, laundry services in a hospital; thirdly, cleaning services in a hospital. From the perspective of those workers, this would allow the minister to essentially contract those things out to for-profit companies. In the same vein, we heard serious concerns about how most workers felt these were integral parts of the health care system, particularly the cleaning services. There were many descriptions given to us about the role played by a number of CUPE workers, in particular, during the SARS crisis and what their incredible responsibilities were around cleaning and disinfecting during the SARS crisis, and that these folks and this function are an integral part of the health care system and should not be contracted out.

The other concern was that because “non-clinical” was not defined, it may mean some of those services and it may mean others. It’s not defined, so it’s not clear exactly what services the minister has in mind when he talks about ordering a hospital to cease providing them and then contracting them out.

The other problem, which the government tries to mitigate somewhat in its amendment 120, is that the rationale puts in a deadline. We heard from the government on a number of occasions that this section was only going to be applicable to certain scenarios, which went unnamed, for a certain period in time. The government has put in a restriction now that a regulation will not be made under this section on or after April 1, 2007. That doesn’t respond to the overwhelming concerns that were heard, which remain; that is, that the minister has the power, has the authority to even overrule the board of the hospital and force that board of the hospital to essentially stop providing the service and contract it out.

Secondly, we have no idea what services are in mind, because “non-clinical services” aren’t defined. Thirdly, the government might say it only applies to some specific changes that are occurring within the ministry now. Those aren’t defined, so the legislation as it is written is very broad and has application to any public hospital and the University of Ottawa Heart Institute. It’s also very unclear who is going to get that service. Clearly, the concern that was raised was that not-for-profit jobs in the hospital or publicly funded jobs in the hospital would now be transferred out to the for-profit sector.

Those are the concerns that were raised. Regrettably, the addition of a date by which this will all be shut down would not go the way to convincing the unions this is a section that should be voted in favour of, and doesn’t do anything to convince me I should vote in favour of it. That is why I’ve made a recommendation to vote against the whole section and the amendments contained therein.

The Chair: Ms Wynne?

1120

Ms. Wynne: I’ll be very brief. I think if we go back in Hansard and look at Ms. Martel’s comments, on a num-

ber of occasions she said that if it’s transitional, then demonstrate it’s transitional and put a date in. That’s exactly what we’ve done. There were people who came in front of us who said that if there are particular processes like the hospital business service process that are in play right now and are going to be completed, then put a date in, at which time this section would no longer pertain. So that’s what we’ve done. The government members went back to the ministry and the minister and said, “This is necessary. We need to demonstrate that this is transitional.” That’s what we’ve done, and I actually would have expected support from Ms. Martel on this amendment.

Ms. Martel: If I might, it’s a shame that Ms. Wynne is being so selective in her memory. I said over and over again that there were a number of concerns with this section. First of all, it was Ms. Wynne who tried to tell various presenters that this section only responded to some integrations that were now under way in the ministry and that we shouldn’t be concerned about it. But there’s nothing in section 33, as it’s currently drafted, and there’s nothing in the proposed amendment by the government that articulates what those processes are.

Ms. Wynne, read section 33. It says very clearly that the government “may, by regulation, order one or more ... entities that operate a public hospital within the meaning of the Public Hospitals Act and the University of Ottawa Heart Institute ... to cease performing any prescribed non-clinical service....” There’s no limitation there. That’s as broad as the number of public hospitals in the province, and there are about 152 of those, and then the Ottawa heart institute. So whatever processes the ministry has in mind are not articulated here, and this section, as it is written, applies to every single hospital in the province of Ontario. Secondly, it gives the minister the authority to order that hospital to stop providing those services, contrary to whatever the board itself may have decided. Thirdly, the non-clinical services are not defined, and that was a concern I raised again and again. Some people might think that’s housekeeping, some people might think it’s laundry or some people might think it’s cafeteria services. First of all, in my opinion, those services are not ones that should be contracted out of a hospital; they are integral to the well functioning of the hospital system, so they shouldn’t be contracted out in the first place, even if that’s what we think. But because there’s no definition, no doubt the minister will be, and certainly could be, under the language written here, much broader than that in terms of which services he decides should cease operating in a hospital and which should be contracted out to the community.

I also raised the concern again and again—and this was raised by any number of presenters—that what this really entailed was the privatization of hospital services. Housekeeping being done now, for example, was going to be contracted out to for-profit companies; cafeteria services that in many hospitals were still paid for—they were employees of the hospital—were going to be contracted out; and there would be a loss of employment for hospital employees, not to mention public sector dollars

going to private sector companies to make some money off the deal. So that concern was raised and this amendment doesn't deal with that either.

The only thing the government has done here in response to the numerous concerns that were raised by presenters and by myself on the public record is to put a date in by which this fiasco might end. It doesn't limit the power of the minister, it doesn't limit the hospitals that he can make orders to, it doesn't limit the kinds of services that he can describe as non-clinical to contract them out, it doesn't limit that contracting out; all it does is limit the day by which he might do all that. That certainly doesn't respond to my concerns and it doesn't respond to the concerns that were raised on this issue.

The Chair: Is there any further debate? If there is none, I will put the question. Shall the motion carry? Those in favour?

Ms. Wynne: Just to be clear, Mr. Chair, we're voting on 119 at this point, right?

The Chair: On 119, yes. Shall the motion carry? Against? The motion carries.

Ms. Wynne again, page 120, please.

Ms. Wynne: I move that section 33 of the bill be amended by adding the following subsections:

"Restriction

"(4.1) The Lieutenant Governor in Council shall not make a regulation under subsection (1) on or after April 1, 2007.

"Revocation of regulations

"(4.2) The Lieutenant Governor in Council may, by regulation, revoke a regulation made under subsection (1) and section 37 does not apply to a regulation made under this subsection."

I think we've talked about this.

The Chair: Any debate?

Mr. Arnott: We may have talked about it [*inaudible*] power until April 1, 2007, what changes are made on that day, if any, and what are they planning to do with this power?

The Chair: Is there any answer?

Ms. Wynne: There are currently some processes in play that need to be completed. We've always said this was a transitional clause in order to allow those integrations to happen and after April 1, 2007, this clause will no longer be in effect. Do you want more detail than that, because that's in effect why we're putting the date in.

Mr. Arnott: Could I have an answer from staff?

Ms. Mill: The April 1, 2007, date is there to reflect the fact that if the bill was passed, April 1, 2007, would likely be the time in which the LHINs would assume all of their final authorities. In that case then, the LHINs would have the authority to effect any types of integration. So as not to have conflict or inconsistency with the Lieutenant Governor in Council having these authorities and the LHINs having these authorities, it reflects that this type of integration would only be able to be effected by the LHINs after that date.

The Chair: Any further debate? If there is no further debate, then I shall put the question.

Ms. Martel: Chair, can I just confirm then that in essence it doesn't diminish the power, it just transfers it from one entity to another, right? That's what the effect of this is. It doesn't diminish the power for these things to happen. It just transfers it from cabinet doing it to the LHINs doing it.

Ms. Wynne: But that's what the bill's about. The bill is about integration. That's why we've got the legislation before us.

Ms. Martel: You've been trying to say this only applies to certain processes, and once these processes are over—these are your exact words—

Ms. Wynne: For the Lieutenant Governor in Council.

Ms. Martel: —then this is not going to happen any more. My argument continues to be—and this has just been confirmed, right?—it's not that these processes are going to end; they're going to start under the minister and then they're going to continue under the LHIN. That's what we had confirmed.

Ms. Wynne: That's what the bill says.

Ms. Martel: Look at the regulation. All the concerns still apply. What you're going to see here, and we heard it again and again, is an effort being made first by the minister and then by the LHINs to off-load any number of services out of the hospital into the community, probably preferably to a for-profit provider at the expense of those in the hospital and spending dollars that should go into patient care instead of going into the profits of those for-profit agencies. Again and again we've heard people say, "This is what the bill is all about: off-loading services out of the hospital somewhere into the community to a for-profit provider." First, the minister's going to do it and then the LHINs are going to do it. That was just confirmed by the comments that were made by staff.

The Chair: Ms. Wynne?

Ms. Wynne: No, it's fine. Clearly, Ms. Martel is not supportive of integrating or coordinating the health system. That's not what she's interested in doing. That's what this bill is about. I will refrain from further comment, but I think it's unfortunate that the status quo suits Ms. Martel just fine.

The Chair: If there is no further debate, then I will put the question. Shall the amendment carry? Those in favour? Those opposed? It does carry.

Now we'll take a vote on the section. Shall section 33, as amended, carry? Those in favour?

Ms. Martel: Recorded vote.

Ayes

Craitor, Matthews, Ramal, Sandals, Wynne.

Nays

Arnott, Martel.

The Chair: It does carry.

We go to section 34, page 120(a), Ms. Wynne.

Ms. Wynne: I move that subsection 34(2) of the bill be struck out and the following substituted:

“Exceptions

“(2) A regulation made under subsection (1) shall not devolve to a local health integration network,

“(a) a power to make regulations under any other act for whose administration the minister is responsible; or

“(b) a power, duty or function that applies to a person described in subsection 2(3) and that exists under the Health Insurance Act, part II of the Commitment to the Future of Medicare Act, 2004 or paragraph 4 of subsection 6(1) of the Ministry of Health and Long-Term Care Act.”

Mr. Ramal: Which one are you reading now?

1130

The Chair: It's a new one: 120a.

Ms. Wynne: It's 120a. Yes. I actually am going to have to ask staff for an explanation on this.

The Chair: Can staff assist us, please? It was the latest piece given to us, for those of you looking for the page.

Mr. Maisey: This proposed amendment would limit the power to devolve under subsection 34(1). It would prevent a devolution of powers to make regulation, which is (2)(a) that's currently proposed in subsection (2).

Subsection (2)(b) is a new limitation. This would prevent the devolution of any power, duty or function as it relates to physicians and other practitioners under the Health Insurance Act, the Commitment to the Future of Medicare Act or in relation to alternate payment plans, family health teams, on-call physicians, those sorts of programs. It's similar to the amendment that was made in respect of assigning agreements under 19(3.1), which was motion number 69.

The Chair: Any debate? If there is no debate, I'll put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Ms. Wynne, 121 and 122, please.

Ms. Wynne: I move that subsection 34(4) of the bill be amended by adding “and the modifications with which the power, duty or function is to apply” at the end.

This clarifies that a regulation devolving certain other powers or duties to a LHIN could include modifications to reflect the change in responsibility. For example, if the provision provided that a particular official had a power or duty and the power was devolved, the regulation could clarify who in the LHIN would exercise that power.

The Chair: Any debate? If there is no debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Ms. Wynne, 122.

Ms. Wynne: I move that subclause 34(5)(a)(ii) of the bill be amended by adding “on or” after “arises.”

This is a technical change which changes “after” to “on or after” with respect to the date that the LHIN is released from liability for powers and duties that are devolved to the LHIN by regulation. It would ensure consistency between the date the LHINs receive their au-

thorities and their protection from liability for exercising those authorities.

The Chair: Any debate? I shall put the question. Shall the motion carry? In favour? Against? It carries.

Shall section 34, as amended, carry? Those in favour? Those opposed? Carried.

Shall section 35 carry? Those in favour? Those opposed? It carries.

The Clerk of the Committee (Ms. Anne Stokes): The new 35.1.

The Chair: Oops. The new 35.1: the government. Sorry. Ms. Wynne, the new 35.1; 122a is the page.

Ms. Wynne: I move that the bill be amended by adding the following section:

“Information for public

“35.1 The minister and each local health integration network shall establish and maintain websites on the Internet and shall publish on their respective websites the documents that the minister or the network, as the case may be, is required to make available to the public under this act.”

I think we discussed this amendment earlier in terms of making documentation public on the LHIN website.

The Chair: Any debate? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Section 36: Mr. Arnott, page 123.

Mr. Arnott: I am prepared to withdraw that amendment.

The Chair: Thank you, Mr. Arnott.

Madam Martel, 124.

Ms. Martel: I move that clause 36(1)(e) of the bill be struck out and the following substituted:

“(e) governing the elections of members of a local health integration network and providing for members' terms of office;”

If previous amendments had been accepted, this would have been the section where the election of LHIN members would have been developed and the process put in place in regulation.

The Chair: Is there any debate on the motion? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry. Therefore, there is no change.

Shall section 36 carry? Those in favour? Those opposed? It does carry.

Section 37, 124a. Madam Martel, please.

Ms. Martel: I move that clause 37(1)(a) of the bill be amended by adding “and on the ministry's website” after “the Ontario Gazette.”

The staff might have to help me, but there is a process for the regulation-making process which is outlined in this section. As I understand it, it allows for information to be posted in the Gazette with respect to regulations that are going to be made under this act. I'm not sure if that information is also posted on the ministry's website, and that's what the aim of the amendment is. But perhaps staff is going to clarify for me whether it's going to be posted in both places.

Ms. Wynne: Sorry, what are we reading?

The Chair: It's two new additions, which are 124a and 124b. We're dealing with 124a. Will the staff be able to assist us, please?

Mr. Maisey: We think it probably is already covered by the new section, 35.1, but it would add clarity to that policy intent.

The Chair: Ms. Martel, are you satisfied?

Ms. Martel: Well, if it would add clarity, I hope the government would accept it. Maybe they want to just hold on this for a second.

The Chair: I will be happy to suppress, if necessary.

Ms. Wynne: I would accept that.

The Chair: Is there any further debate? If there is none, I will put—

The Clerk of the Committee: No, Michael has something.

The Chair: Oh, sorry. Mr. Wood, can we have one minute, please?

Mr. Wood: I agree with the opinion just expressed by the counsel from the Ministry of Health and Long-Term Care that this would be redundant, in light of government motion 122a, to add the new section 35.1 of the act. If we passed motion 124a, it would perhaps raise the danger that by being redundant, it might call into question the effect of section 35.1.

The Chair: All right. Any debate on the other side, of staff?

Ms. Martel: Now I'm totally lost. All I was trying to do was make sure that the regulations that were being proposed under this section would appear in two places: in the Ontario Gazette, which they would normally, and on the ministry's website. I'm not clear, as to the last round of discussion, what the problem is here.

Ms. Mill: Okay. I think that the legal opinion being expressed by both legislative counsel and ministry counsel is that this would actually be taken care of under the new 35.1. I think legislative counsel is now expressing a concern that if we did in fact add this new amendment in, as being proposed in 124a, it might give rise to questions as to what we were actually meaning in 35.1, that perhaps we were not meaning to have the regulations posted because we found it necessary to be much more clear here in this section. I'm assuming that the legal advice is actually to leave it just in 35.1 and not make this change in order to avoid that conflict.

Mr. Wood: That is correct.

The Chair: So what is your opinion on that?

Ms. Martel: Can I ask a question: because 35.1 is silent on what would be posted?

Ms. Mill: Well, 35.1 basically says that any documents that are being required under this act, which presumably would include the regulations, would have to be published on the ministry website, but also presumably—I'm now actually looking at legislative counsel and my counsel here—would require it being posted on the LHIN website?

Mr. Maisey: No, I don't think it's under the LHIN website, sorry. That's a bit of a confusion. Section 35.1

requires the minister to make public on the ministry's website any document that is required to be made available to the public under this act. It's our view that a notice of a proposed regulation has to be made public, and therefore would be made public on the ministry's website.

The Chair: Are you satisfied?

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Ms. Martel: Okay. All right, if that's the case—

Ms. Wynne: We'd like to support this if Ms. Martel wants to continue to put it forward. But are you going to withdraw it, or—

Ms. Martel: Those documents are different from the regulation-making process itself; that's what I was trying to get clarity on. So if you are telling us that it is the intention that those be posted, then I will—

Ms. Mill: That's correct.

Ms. Martel: So I withdraw.

The Chair: Withdraw that section. You still have the floor—124b.

Ms. Martel: Sorry, Chair. Now I'm just not sure if the next one has become—

The Chair: Do you need some assistance from staff on that? Can staff answer the question? Do we still need 124b? Well, is it relevant, is the question.

Ms. Mill: If I understand motion 124b, it would actually strike out subsection 37(2). That section deals with exceptions to the requirement to have a public consultation period on the regulations. So this is different from the previous motion.

The Chair: Okay, thank you. So you still have the floor.

Ms. Martel: Then I would move that subsection 37(2) of the bill be struck out.

That is an exemption clause, and I'm sorry that I didn't pick that up quicker. It would be my view that, given the changes that the government has talked about will come with this legislation, there should be public notice for all of the regulations. There should not be an exemption.

The Chair: Any debate? If there is no debate, then I shall call the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Ms. Wynne, page 125.

Ms. Wynne: I move that subsection 37(6) of the bill be struck out and the following substituted:

"Discretion to make regulations

"(6) Upon receiving the minister's report mentioned in clause (1)(e), the Lieutenant Governor in Council, without further notice under subsection (1), may make the proposed regulation with the changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the minister's report.

"Same, minister's regulations

"(6.1) If the minister may make the proposed regulation and the conditions set out in subsection (1) have been met, the minister, without further notice under that subsection, may make the proposed regulation with the changes that the minister considers appropriate."

This clarifies that, with respect to Lieutenant Governor in Council regulations, the minister must provide the Lieutenant Governor in Council with recommendations for changes, if any, to the proposed regulation, but that this step is not necessary for minister regulations.

The Chair: Any debate? If there is no debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? The motion does carry.

Page 126, Ms. Wynne.

Ms. Wynne: I move that subsections 37(7) and (8) of the bill be amended by striking out “and (6)” wherever that expression appears and substituting in each case “(6) and (6.1).”

This is a technical amendment that reflects other amendments.

The Chair: Any debate? If there is no debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Mr. Arnott, 127.

Mr. Arnott: I move that subsection 37(13) of the bill be amended by striking out “21 days” and substituting “60 days.”

It's my understanding that the Ontario Long Term Care Association has requested this amendment based on their belief, which is supported by our party, that the proposed timelines for seeking a judicial review are unrealistically short, as proposed in the original Bill 36. This amendment would extend the timelines to a more reasonable period.

The Chair: Is there any debate on the motion?

Ms. Wynne: Just, Mr. Chair, that the 21 days is consistent with other health legislation. That's why we've used it here.

The Chair: Is there any further debate?

Mr. Arnott: Does the parliamentary assistant think that 21 days is sufficient just because it's in other aspects of health legislation?

Ms. Wynne: Well, I think that if it works in other contexts, then it will work in this context. So that's why we're supporting that time frame.

Mr. Arnott: I submit that it doesn't work; 60 days is required.

The Chair: Any further debate? If there is no further debate, then I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 37—

The Clerk of the Committee: Michael would like to speak.

The Chair: Yes.

Mr. Wood: Since the committee has passed the motion to strike out subsection (2) of section 37, it becomes necessary to make a minor change to subsection 37(1), which contains a cross-reference to the now non-existent subsection (2). So, with the committee's indulgence, I wonder if I could have a few minutes to draft up a motion and if we could stand down consideration of the vote on section 37.

The Chair: Fine. If there's no disagreement, we'll do that. Can we deal with section 37.1, new? Okay. So stand down the actual section.

Therefore, section 37.1 is a new one. Mr. Arnott, page 128, please.

Mr. Arnott: I move that the bill be amended by adding the following section:

“Review of act and regulations

“37.1(1) A committee of the Legislative Assembly shall,

“(a) begin a comprehensive review of this act and the regulations made under it no earlier than two years and no later than three years after this act receives royal assent; and

“(b) within one year after beginning that review, make recommendations to the assembly concerning amendments to this act and the regulations made under it.

“Definition

“(2) In this section, ‘year’ means a period of 365 consecutive days or, if the period includes February 29, 366 consecutive days.” A leap year.

Interjections.

Ms. Wynne: Are you reading 128? Because that's not—

The Chair: Everybody seems to have it. Are you the only one?

Mr. Wood: No. There's been a replacement.

Ms. Wynne: I know, but we don't have that language.

Interjections.

The Chair: You all seem to have one. Okay. It seems to me that everybody has, except you. Am I correct?

Ms. Wynne: No, nobody has it. Only Anne has it.

The Chair: Okay, fine. So we have a problem. We have to wait until she comes back—wait the motion before we can continue discussions. Am I right?

Ms. Wynne: Can we move on to the next one?

The Chair: Unfortunately, we can't. It looks like we'll have at least a few minutes of break until she comes back.

The Clerk of the Committee: We can stand down.

The Chair: We'll stand it down. When the photocopy comes back, we'll deal—how about section 38? Shall section 38 carry? Those in favour? Those opposed? Carried.

Section 39: Ms. Wynne, page 129.

Ms. Wynne: I move that the bill be amended by adding the following subsection:

“(7.1) Subsection 6(1) of the act is amended by striking out ‘or a regulation.’”

Subsection 39(24) of the bill repeals the minister's authority to make regulations prescribing restrictions on the capacity, rights, powers or privileges of CCACs. Subsection 6(1) of the CCAC act, 2001, deals with restrictions on CCACs' power and refers to this regulation-making authority. Since the minister's regulation-making authority is being removed, subsection 6(1) of the CCAC has to be amended to remove the words “or a regulation” from the end of it.

The Chair: Any debate? If there is no debate, I'll put the question. Shall the motion carry? Those in favour? Those opposed? Carries.

Ms. Wynne, 130.

Ms. Wynne: I move that subsection 12(2) of the Community Care Access Corporations Act, 2001, as set out in subsection 39(15) of the bill, be struck out and the following substituted:

"Auditor's report

"(2) Each community care access corporation shall give a copy of every auditor's report for a fiscal year of the corporation to the minister within six months after the end of that fiscal year, if that fiscal year ends before the day before the first anniversary of the day on which subsection 39(15) of the Local Health System Integration Act, 2005 comes into force."

What this does is it clarifies that the CCAC auditor's report is provided to the minister for the time during which the directors are appointed by the government. This obligation would continue for the fiscal years prior to the repeal of the obligation. This is in the transition between the current board structure to the new board structure.

The Chair: Any debate? If there's no debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Page 131, please.

Ms. Wynne: I move that subsection 13(1) of the Community Care Access Corporations Act, 2001, as set out in subsection 39(16) of the bill, be struck out and the following substituted:

"Annual report

"13(1) Each community care access corporation shall give an annual report on its affairs for the preceding fiscal year to the minister within six months after the end of that fiscal year, if that fiscal year ends before the day before the first anniversary of the day on which subsection 39(16) of the Local Health System Integration Act, 2005 comes into force."

This is the same argument but for the annual report.

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The Chair: Any debate on the motion? If there is none, I will put the question. Shall the motion carry? Those in favour? Opposed? It carries.

Page 132.

Ms. Wynne: I'm going to ask Ms. Matthews to read this one, if she has it in front of her.

Ms. Deborah Matthews (London North Centre): Certainly. I move that section 15.3 of the Community Care Access Corporations Act, 2001, as set out in subsection 39(18) of the bill, be amended by striking out the portion before paragraph 1 and substituting the following:

"Amalgamation of corporations

"15.3 If a regulation made under subsection 15(1) amalgamates two or more community care access corporations into one corporation, the following rules apply."

The Chair: Is there any debate on the motion? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Page 133, please.

Ms. Matthews: I move that section 15.3 of the Community Care Access Corporations Act, 2001, as set out in subsection 39(18) of the bill, be amended by adding the following subsection:

"Conflict

"(2) None of the following shall conflict with the rules set out in subsection (1):

"1. A regulation made by the Lieutenant Governor in Council under subsection 15(1).

"2. An order made by the minister under subsection 15(3), unless it specifies otherwise with respect to a matter dealt with in paragraph 3 or 6 of subsection (1)."

The Chair: Any debate on the motion? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Ms. Matthews, 134.

Ms. Matthews: I move that the French version of subsection 16.1(5) of the Community Care Access Corporations Act, 2001, as set out in subsection 39(18) of the bill, be amended by striking out "(1) et (4)" and substituting "(1) à (4)."

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Ms. Matthews, 135.

Ms. Matthews: I move that subsection 16.2(1) of the Community Care Access Corporations Act, 2001, as set out in subsection 39(18) of the bill, be amended by adding "any direct or indirect action that the minister takes under this act, including under" after "arising from."

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Ms. Matthews, 136.

Ms. Matthews: I move that section 16.2 of the Community Care Access Corporations Act, 2001, as set out in subsection 39(18) of the bill, be amended by adding the following subsection:

"No expropriation

"(4) Nothing in this act and nothing done or not done in accordance with this act constitutes an expropriation or injurious affection for the purposes of the Expropriations Act or otherwise at law."

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Ms. Matthews, 137.

Ms. Matthews: I move that subsection 39(21) of the bill be struck out and the following substituted:

"(21) Section 18 of the act is repealed and the following substituted:

"Information for the public

"18. The minister shall make available to the public,

"(a) every report of a community care access corporation on its affairs given to the minister under this act; and

“(b) every report of the auditors of a community care access corporation on a report mentioned in clause (a).”

The Chair: Is there any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Ms. Matthews, 138.

Ms. Matthews: I move that subsections 39(25), (26) and (27) of the bill be struck out and the following substituted:

“(26) Section 23 of the act is repealed and the following substituted:

“Repeal

“23. Subsection 12(2), sections 13 and 18 and this section are repealed on a day to be named by proclamation of the Lieutenant Governor.”

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Shall section 39, as amended, carry? Those in favour? Those opposed? It does carry.

Are we ready to deal with Mr. Arnott, 128, section 37.1?

The Clerk of the Committee: No, I think the first one we would do—

The Chair: It's the stand down—

The Clerk of the Committee: You stood down section 37 to deal with this motion that Michael Wood just mentioned, so I'll hand it out now.

The Chair: Would you please do that? Mr. Wood, do you have any explanation to give us in addition?

Mr. Wood: I'll repeat the explanation I gave earlier. The committee, by way of motion, struck out subsection 37(2) of the bill. There is presently cross-reference to subsection 37(2) in subsection 37(1), so therefore it becomes necessary to amend subsection 37(1) to strike out the cross-reference to the non-existent subsection (2).

The Chair: Any questions or any debate? It's the item that we stood down.

Mr. Arnott: I don't have a copy of my amendment, unfortunately.

The Chair: You were just given it. We got it. I'll give you mine. I'm asking if there are any questions or debate, while you're getting it.

Mrs. Liz Sandals (Guelph-Wellington): So this is the new one from legislative counsel.

The Chair: Yes. You heard the explanation from Mr. Wood. If anybody has a question, first of all, for Mr. Wood, and if there are no questions, then I'll open the floor for any debate, and then we may take a vote. No questions. Any debate? If there is none, then I will put the question.

The Clerk of the Committee: Somebody has to move it.

The Chair: I'm sorry. Would Ms. Wynne move it?

Ms. Wynne: I move that subsection 37(1) of the bill be amended by striking out “subsections (2) and (8)” and substituting “subsection (8).”

The Chair: Since the motion is on the floor, then I'll ask, is there any debate on the motion? If there is no

debate, then I will put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 37, as amended, carry? Those in favour? Those opposed? It carries. So we've dealt with section 37.

The Clerk of the Committee: Now you do 37.1.

The Chair: It's motion 128.

The Clerk of the Committee: Nobody had it. Did you already move it?

Mr. Arnott: Yes, I moved it.

Mr. Wood: To assist members of the committee in locating the correct motion, if you look on the top right-hand corner, under “PC Motion,” it says “v.2” instead of “v.1.”

The Chair: It's my understanding that this motion is already on the record.

Mr. Arnott: Could I just offer a word of explanation? I'm told that this has been requested by the city of Toronto, in principle. Most other provinces across Canada, if not all, have some form of regional health authorities, as has been pointed out during the course of these hearings. It's my understanding that most of these experiences have shown over a period of time that the structure doesn't always work as intended, and that's been our experience across the country.

The LHIN structure is unique in Canada. Therefore, it would be prudent, given the experience in other provinces and the uniqueness of our own proposed structure, for a committee of the Legislature to review the system and make recommendations for improvement at some point down the road. A committee of the Legislative Assembly would be the strongest possible way to do this review—and, I would add, in a public forum—to demonstrate the government's commitment to ensuring the success of this exercise in improving Ontarians' access to high-quality health care.

The Chair: Any more comments from you, Mr. Arnott? Any debate?

Ms. Wynne: I would be prepared to support this amendment but the two and three years are still giving us a problem. We want to make sure there is enough time to know whether things are working. So we're suggesting that, if it could be adjusted to three and four years, “no earlier than three years and no later than four years,” we'd be willing to accept it.

Mr. Arnott: So are you making an amendment?

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Ms. Wynne: Indeed. I'm going to propose an amendment:

“(a) begin a comprehensive review of this act and the regulations made under it no earlier than three years and no later than four years after this act receives royal assent; and” etc.

The Chair: So that's an amendment. I will deal with the amendment first. That's the way we operate here. That's normally the case.

Ms. Wynne: Is everybody clear?

The Chair: Everybody's clear, otherwise they will let me know. Is there any debate on the amendment? If

there's no debate on the amendment, I will put the question. Shall the amendment to the motion carry? Those in favour? Those opposed? It carries.

Now there is an amended motion. Is there any debate on the motion, as amended? If there is none, I will put the question. Shall the motion, as amended, carry? Those in favour? Those opposed?

You're in favour? It's your motion, right?

Mr. Arnott: I was in favour of the amendment to the motion.

The Chair: Anyway, it still carries.

The Clerk of the Committee: No, wait a second.

The Chair: It does carry.

Mr. Arnott: You carried my amendment, actually.

The Clerk of the Committee: The amendment to the motion carried. Now it's the motion, as amended. That's what we're voting on now.

The Chair: That is what we just voted on, and it carries.

The Clerk of the Committee: I know. Mario, you have to slow down. I have to keep up too.

The Chair: All right. It carries. Thank you.

The next item—we've got to go back to section 40. Is that the next section?

Ms. Wynne: We just finished motion 138.

The Chair: Are we on section 40, which means page 138a? Is everybody on the same page? Madam Martel, please.

Ms. Martel: I move that the definition of "health services integration" in section 2 of the Public Sector Labour Relations Transition Act, 1997, as set out in subsection 40(1) of the bill, be struck out and the following substitute:

"'health services integration' means an integration that affects the structure or existence of one or more employees or that affects the provision of programs, services or functions by the employers, including not limited to an integration that involves a dissolution, amalgamation, division, rationalization, consolidation, transfer, tendering, retendering, merger, commencement or discontinuance, where every major employer subject to the integration is either,

"(a) a health service provider within the meaning of the Local Health System Integration Act, 2005, or

"(b) an employer who provides or, immediately following the integration, will provide services within or to the health services sector; ('intégration des services de santé')"

This would have allowed for PSLRTA to apply to a broader integration, so it would not be restricted to the integrations where the successor employer does not have a primary function in health care. It's related to previous amendments that I moved to try and broaden the application of PSLRTA.

The Chair: Any debate? If there's no debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Martel, 138b.

Ms. Martel: I move that subsection 9(7) of the Public Sector Labour Relations Transition Act, 1997, as set out in subsection 40(4) of the bill, be struck out.

As it currently stands, as the bill is drafted, it says that under subsection 9(7) PSLRTA does not apply to an employer in the health sector who is the crown or where the crown is the employer. By striking out this section, this would now apply to the crown as the employer, and bargaining agents could go to the board then to try and get covered under PSLRTA. So it's providing an obligation essentially for the crown to have to participate under this act.

The Chair: Any debate on the motion? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry. It's two to one, so it doesn't carry. Sorry.

The next one is 138c.

Ms. Martel: I move that subsection 40(7) of the bill be amended by striking out "Subsection 12(2) of the act is" and substituting "Subsections 12(2) and (3) of the act are."

This is an amendment that follows from the previous amendments where we're trying to get the Public Sector Labour Relations Act to apply also to the crown. This is an associated amendment, trying to achieve that aim.

The Chair: Any debate? If there's no debate, I'll put the question. Those in favour? Those opposed? It does not carry.

Shall section 40 carry? Those in favour of section 40? Those opposed? It does carry.

Shall section 41 carry? Those in favour? Those opposed? It carries.

Section 42. The first one is Madam Martel. I believe it's page 138d.

Ms. Martel: I move that subsection 31(2) of the Commitment to the Future of Medicare Act, 2004, as set out in subsection 42(49) of the bill, be amended by striking out "when required to do so by the minister or a local health integration network."

The rationale for the change is that I think that a health service provider should always have to post copies of the accountability agreement in a conspicuous place and not just do so when directed by the LHIN or the minister.

Now there were some changes—

Ms. Mill: I don't have that motion.

The Chair: You don't? It's 138d and 138e. Does the clerk have it?

Ms. Wynne: We've got d and e.

The Chair: Can someone provide a copy to staff? Is that possible?

Ms. Wynne: Can you just hold on a second?

The Chair: Yes. We will see if we can get a copy right away; otherwise, we'll have to take a break again.

Okay. You've already introduced 138d. Is there any debate?

Interjection.

The Chair: Yes. Anybody else?

Let me know when we are ready, Ms. Wynne.

Ms. Wynne: I'm just wondering whether it's possible to move on to another section. Can we do that? Could we stand those down? Is that possible?

The Chair: Yes, we can do that.

Does the committee agree on standing down? Okay.

Ms. Martel: Chair, I had wanted to ask a question of legislative counsel because I believe there was a change made about posting of accountability agreements in workplaces. I don't remember the exact reference and whether it was a requirement always or not. So it may be that it's been covered. I was going to give that information to the staff before we started looking for the amendment. So if that helps—

Ms. Wynne: Are you referring to motion 45?

Ms. Martel: The one we were just dealing with, yes, that's been stood down. But I can deal with the next one if you want. It may well have been covered and I'm just not clear about that. So I'll deal with the next one, then?

Ms. Wynne: Well, they're looking at 138e as well.

The Chair: They're looking at that too. Why don't we then go to 139, to you, Ms. Wynne, and then we'll deal with your two?

Ms. Martel: I have a 138d and e. Does staff now have both?

Ms. Wynne: They have both.

Ms. Martel: Okay. So we're moving to 139.

Ms. Wynne: I move that subsections 31(2) and (3) of the Commitment to the Future of Medicare Act, 2004, as set out in subsection 42(49) of the bill, be amended by striking out "service accountability agreement" wherever that expression appears.

This revision—it refers to motion 45—removes service accountability agreements from the list of documents the minister may require a health service provider to post and adds a new subsection to deal with the public disclosure of service accountability agreements.

The Chair: Any debate?

Ms. Martel: Sorry? I'm just confused about—currently, it is a requirement to post?

Ms. Wynne: Yes. I think the issue is that currently that would be one of the documents, and we've got a new process in place for those documents.

The Chair: Staff?

Mr. Maisey: This relates to motions 138d and e, I believe. Currently, the provision in subsection 31(2) is that the health service provider is only required to post the service accountability agreement when the minister or the LHIN requires it to do so. Government motion 139 strikes out the reference to "service accountability agreement" in subsections 31(2) and (3), and government motion number 140 then adds two new subsections, the effect of which is to require the minister and the LHIN to make the service accountability agreement public and to require the health resource provider to post the service accountability agreement as well, in the sites of operations to which the service accountability agreement relates.

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Ms. Martel: So it's going to be a requirement that they do that regardless.

Mr. Maisey: It's an absolute requirement. It's not at the minister's discretion.

The Chair: Any further debate on the motion? If there's none, then I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Motion 140, Ms. Wynne.

Ms. Wynne: I move that section 31 of the Commitment to the Future of Medicare Act, 2004, be amended by adding the following subsections:

"Service accountability agreement

"(3.1) The minister or a local health integration network shall make copies of any service accountability agreement that the minister or the network, as the case may be, has entered into with a health resource provider available to the public at the offices of the ministry or the network, as the case may be, even if this results in the disclosure of personal information.

"Same, health resource provider

"(3.2) A health resource provider shall post a copy of its service accountability agreement in a conspicuous public place at the health resource provider's sites of operations to which the agreement applies and on its public website on the Internet, if any, even if this results in the disclosure of personal information."

We will be supporting this amendment, obviously, and I think it takes care of what the member for Nickel Belt was bringing forward in 138(d) and (e).

The Chair: Any debate on this motion? If there is no debate, I shall put the question. Shall the motion carry? Those in favour? Those opposed? That's carried.

Ms. Wynne, 141 please.

Ms. Wynne: I move that subsections 32(1) and (2) of the Commitment to the Future of Medicare Act, 2004, as set out in subsection 42(50) of the bill, be amended by adding "a director or officer of a local health integration network" after "the minister, a local health integration network" in each subsection.

The Chair: Any debate? If there's no debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? Carries.

Can we deal now with 138(d) and (e)? Are we ready? Ms. Wynne, is staff ready?

Ms. Wynne: Yes. I just want to reiterate that I won't be supporting (d) and (e) because 139 and 140 have taken care of this.

The Chair: Terrific. Do we have 138(d) on the record?

The Clerk of the Committee: Yes.

The Chair: The motion is on the floor. Is there any further debate on your motion?

Ms. Martel: No, I'm happy that the government dealt with my concern, so I'll withdraw the amendment.

The Chair: Oh, you will withdraw it? Terrific. That's for 138(d). How about 138(e)? Would you like to introduce it?

Ms. Martel: I'm going to take their word for it that they did. They're nodding, so I will withdraw that one as well.

The Chair: You'll withdraw it. Thank you.

So we've dealt with this section. Shall section 42, as amended, carry? Those in favour? Those opposed? That's carried.

Shall section 43 carry? Those in favour? Opposed? Carries.

Shall section 44 carry? Those in favour? Opposed? Carries.

Shall section 45 carry? Those in favour? Against? Carries.

Shall section 46 carry? Those in favour? Against? Carries.

Section 47: Mr. Arnott, page 142.

Mr. Arnott: I move that section 20.13(1) of the Nursing Homes Act, as set out in subsection 47(7) of the bill, be amended by striking out "minister may" and substituting "minister shall."

This is an amendment that's been requested by the Ontario Long Term Care Association. As written, Bill 36 currently has, as I understand it, no amendment for the minister to continue funding homes under this act and this amendment would make ongoing funding a legal requirement. Long-term-care homes are currently funded on a retroactive basis, I'm told, and changing the language to "may" opens the door to the possibility that funding for services rendered may not be forthcoming from the ministry to the LHINs, and then from the LHINs to the providers. This is an untenable situation that introduces risk where risk should not be introduced, and creates uncertainty where uncertainty should not be.

The Chair: Thank you very much for the explanation. Is there any debate on the motion? If there's none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Mr. Arnott, 143.

Mr. Arnott: I move that subsection 47(8) of the bill be struck out and the following substituted:

"(8) Section 20.15 of the act is repealed."

Again this is an amendment that has been requested by the Ontario Long Term Care Association. It's my understanding that currently the minister may allocate additional funds to a licensee to assist in defraying the costs incurred or to be incurred as a result of the occurrence of an extraordinary event prescribed by the regulations. This is important, as it allows for the protection of nursing homes from unforeseen costs such as those incurred during a pandemic outbreak or a natural disaster. Bill 36, as written, I'm told, does not address this issue and adopting this amendment preserves the ministerial authority contained in the Nursing Homes Act.

The Chair: Is there any debate on the motion? If there's none, I shall put the question. Shall the amendment carry? Those in favour? Those against? It does not carry.

Shall section 47 carry? Those in favour? Those against? It carries.

Section 48: Madam Wynne, 144.

Ms. Wynne: I move that section 48 of the bill be amended by adding the following subsection:

"(0.1) The Pay Equity Act is amended by adding the following section:

"Application of s. 13.1 in other circumstances

"13.2 Section 13.1 applies with respect to an event to which the Public Sector Labour Relations Transition Act, 1997, applies in accordance with the Local Health System Integration Act, 2005."

This corrects an omission in making this consequential amendment that would ensure consistency in the application of pay equity provisions when the Public Sector Labour Relations Transition Act, 1997, applies to integrations under this bill.

The Chair: Any debate? If there is no debate, I will put the question. Shall the amendment carry? Those in favour? Those opposed? That's carried.

Number 145, Ms. Wynne, please.

Ms. Wynne: I move that subsections 48(1) and (2) of the bill be struck out and the following substituted:

"(1) Clauses 1(d), (h), (h.1), (i) and (j) under the Ministry of Health in the appendix to the schedule to the act are amended by adding 'or a local health integration network as defined in section 2 of the Local Health System Integration Act, 2005' at the end of each clause."

This is a drafting error being corrected.

The Chair: Any debate? If there is no debate, I will put the question. Shall the motion carry? Those in favour? Those against? It carries.

Shall section 48, as amended, carry? Those in favour? Those against? It carries.

Shall section 49 carry? Those in favour? Those against? Carries.

Section 50: Mr. Arnott, page 146.

Mr. Arnott: I move that subsection 50(11) of the bill be struck out.

I understand this was requested by the Hospital for Sick Children in Toronto and the Association for Healthcare Philanthropy. I'm told that the ministry has an established policy for the settlement reached with foundations in 1998 that will not require this reporting and should seize this opportunity to bring the act into alignment with the policy. That's what Sick Kids' Hospital has advised us.

Stakeholder uncertainty: This bill purports to broaden the scope of a provision that has not been used in eight years and the minister has previously agreed not to use. Again, that's advice from the Association for Healthcare Philanthropy.

The Chair: Is there any debate?

Ms. Wynne: I'll be supporting this amendment and we'll actually withdraw the next amendment because we agree.

The Chair: Any further debate? If there's no debate, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

The next one has been withdrawn. Shall section 50, as amended, carry? Those in favour? Those opposed? Carries.

Section 51: Ms. Wynne, 148.

Ms. Wynne: I move that subsections 51(1) and (2) of the bill be struck out and the following substituted:

“51(1) Clauses 1(d), (h), (i), (j) and (k) under the Ministry of Health in the appendix to the schedule to the Social Contract Act, 1993 are amended by adding ‘or a local health integration network as defined in section 2 of the Local Health System Integration Act, 2005’ at the end of each clause.”

Again, this is a technical drafting error that’s being corrected.

1220

The Chair: Any debate on the motion? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? The motion does carry.

Shall section 51, as amended, carry? Those in favour? Those opposed? It carries.

Shall section 52 carry? Those in favour? Those opposed? It carries.

Shall sections 53 and 54 carry? Those in favour? Those opposed? Both of them carry.

Ms. Martel, preamble 1, please.

Ms. Martel: I move that the preamble to the bill be amended by adding the following clause:

“(0.a) affirm their continued commitment to the values set out in the preamble to the Commitment to the Future of Medicare Act, 2004, including,

“(i) that medicare—our system of publicly funded health services—reflects fundamental Canadian values and that its preservation is essential for the health of Ontarians now and in the future,

“(ii) that two-tier medicine, extra billing and user fees should continue to be prohibited in accordance with the Canada Health Act, and

“(iii) that access to community-based health care, including primary health care, home care based on assessed need and community mental health care are cornerstones of an effective health care system;”

If I might, Mr. Chair?

The Chair: You read it into the record. Before you get into any explanation, let me say this: In the case of a bill that has been referred to committee after second reading, a substantive amendment to the preamble is permissible only if it is rendered necessary by amendments made to the bill. I find that the bill has not been amended in such a way as to warrant this amendment to the preamble. I therefore find this amendment out of order.

Ms. Martel: Yes, and further to that, because there are a number of amendments from all parties, I’m going to ask for unanimous consent that all the amendments from the parties to the preamble section be allowed to be put and debated etc.

The Chair: Terrific. So then I have a motion on the floor now. We are just doing one each time, or are we going to take all of them at once?

The Clerk of the Committee: It should be done each time.

The Chair: So we’ll take yours, and each time we’ve got to go through this. Therefore, Ms. Martel has asked

that unanimous support be given, otherwise we cannot deal with this matter. I will take the vote at this time. Do I have unanimous consent? Okay. Now we can debate.

Ms. Martel: Thank you, Mr. Chair.

The Chair: You can tell me all you want.

Ms. Martel: Very good, Mr. Chair. Thank you.

We had a number of presenters who came before the committee who expressed significant concerns about this bill and where it was heading, and in fact made a point to confirm that there was no reference in the bill to either Bill 8, the Commitment to the Future of Medicare Act, or any reference to the Canada Health Act and its principles. With respect to health care, health care is a core value for Ontarians and Canadians, and these things are integral. It’s also my hope, as an aside, that the bill will promote these and not take away from them, but I guess time will tell.

I know that the government has an amendment that references both the commitment to medicare act and the Canada Health Act. What the government’s amendment to the preamble doesn’t include, however, would be point (iii), that access to community-based care, primary health care, home care and community mental health care are cornerstones of an effective health care system. I’ve added that in this section as well because I’d like the bill to make it clear that these sectors, sometimes traditionally given short shrift in terms of funding or policy or other considerations, are essential as well, that the system is bigger than hospitals. While hospitals are important, there must be solid recognition that these other sectors are just as important to people’s quality of life and well-being. So that was what the third bullet point also tried to address.

The Chair: Any debate? If there is no debate, then I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Wynne.

Ms. Wynne: Mr. Chair, I assume I have to ask for unanimous consent to bring this motion to the preamble?

The Chair: Yes. Do we have unanimous consent? Yes, you do.

Ms. Wynne: Thank you. Does everyone have version 6? It’s government motion version 6.

I move that the preamble to the bill be amended by adding the following clauses:

“(0.a) confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility and accountability as provided in the Canada Health Act (Canada) and the Commitment to the Future of Medicare Act, 2004;

“(0.a.1) are committed to the promotion of the delivery of public health services by not-for-profit organizations;”

We believe that this language addresses the concerns of the folks who came before us.

The Chair: Is there any debate on this motion? If there’s no debate—

Ms. Wynne: Could we have a recorded vote?

Ayes

Martel, Orazietti, Ramal, Sandals, Wynne.

The Chair: Those opposed? The motion carries.

Mr. Arnott, yours is next. First of all, do I have unanimous consent for Mr. Arnott's motion? Yes, we do. Go ahead, Mr. Arnott.

Interjection.

The Chair: We're doing clause (e), which is page 3.

Interjection.

The Chair: From the NPD. I'm sorry, Mr. Arnott. Back you to you, Madam Martel.

Ms. Martel: I ask for unanimous consent.

The Chair: Do I have unanimous consent? Yes.

Ms. Martel: I move that the preamble to the bill be amended by adding the following clause:

"(0.a.1) acknowledge that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

This came from a number of presenters who represented organizations in the mental health field, to ask us to broaden the definition of "health" to be all-inclusive, and that's what the intention of the amendment is.

The Chair: Any debate on the motion? If there's no debate, I shall put the question. Shall the motion carry? Those in favour?

Ms. Martel: Could I have a recorded vote?

Ayes

Martel.

Nays

Orazietti, Ramal, Sandals, Wynne.

The Chair: The motion does not carry.

Now we go back to the PC clause (e) motion. Do we have unanimous consent for Mr. Arnott? Okay, we do.

Mr. Arnott: I move that clause (e) of the preamble to the bill be amended by striking out "aboriginal peoples" and substituting "aboriginal communities."

It's my understanding that this amendment has been requested by the Noojimawin Health Authority, because they rightly state that aboriginal Canadians live in both urban and rural settings, and replacing the word "peoples" with "communities" acknowledges that there is not just one uniform aboriginal group. It is important that this fact be recognized in the preamble, and I would hope the government will offer the passage of this amendment.

The Chair: Is there any debate on the motion?

Ms. Wynne: We've used the "aboriginal peoples" language in other places in the bill, and it's our contention that we need to be consistent.

The Chair: Any further debate? If there's none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Do I have unanimous consent for NDP preamble 4? We do. Madam Martel, would you please introduce your motion?

Ms. Martel: I move that the preamble to the bill be amended by adding the following clause:

"(e. 1) recognize the role of Franco-Ontarians in the planning and delivery of health services in their communities;"

We had a number of representations from organizations representing francophone communities. We know that there is a report that has been done. We haven't seen the details of that, so we don't know what will happen to that report and how it will impact on the bill or on LHINs.

1230

There were a number of recommendations, potential amendments, however, that were given to the committee near the end of the hearings by an organization called Alliance des réseaux ontariens des services de santé en français. One of those amendments had to do with encouraging the committee to recognize the role of Franco-Ontarians in planning and delivery of health services in the health care system, in the same way that the preamble currently recognizes the role of First Nations in clause (e). The intention is to respond to the concerns that were raised, respond to the request for an amendment that was made, and also have in legislation an amendment that patterns the language that is in the preamble of the bill now with respect to recognition of First Nations and aboriginal peoples.

The Chair: Is there any debate?

Ms. Wynne: We've made a substantive amendment on the role of francophones in the body of the bill, and clause (d) does make reference to the French Language Services Act, so I won't be supporting this amendment.

The Chair: Any further debate? If there's none, I'll put the question. A recorded vote.

Ayes

Arnott, Martel.

Nays

Orazietti, Ramal, Sandals, Wynne.

The Chair: It does not carry.

First of all, do I have unanimous support for the Liberal amendment to preamble 5? We do.

Ms. Wynne: I move that clause (f) of the preamble to the bill be amended by adding "continuous quality improvement and" after "promotes."

This adds to the preamble the recognition that one of the goals is to promote continuous quality improvement of the health system.

The Chair: Any debate? If there's no debate, I'll take the vote. Shall the motion carry? Those in favour? Those opposed? It carries.

NDP amendment to preamble number 6: Do I have unanimous support? Okay. Please proceed, Madam Martel.

Ms. Martel: I move that the preamble to the bill be amended by adding the following clauses:

“(f.1) respect health care professionals and confirm that they are fundamental to the delivery of quality health care and have the right to equitable terms and conditions of employment regardless of where they work in the health care system;

“(f.2) recognize that the current shortage of health care professionals and workers needs to be addressed;

“(f.3) confirm that regional disparities in the availability of health care within Ontario need to be addressed;

“(f.4) recognize that patients who are required to travel for medical care as a result of an integration under this act should be reimbursed for costs incurred in relation to such travel.”

This change comes from both the Ontario Nurses' Association and OPSEU. It recognizes a number of issues that were raised during the course of the public hearings:

—that workers are on the front line, and we need to remember that in terms of any restructuring that's done in the health care system;

—secondly, that part of what the LHINs will not be able to address, frankly, in terms of their roles and responsibilities still needs to be addressed, and that is a shortage of health care professionals broadly;

—thirdly, that there are disparities in health care. Again, that can only be addressed by the funding that's

going to be provided by the government to different LHINs to try and address that, but that is something that needs to be addressed;

—finally, as a result of consolidation and integration, particularly in the hospital sector, the valid concern that was raised and repeated through the course of the hearings is that services that may now be available in a small community hospital will no longer be available, that they will be consolidated into larger regional centres or a regional hospital, and that, as a result, people who would not be travelling for care now will have to in the future. That is also an issue that needs to be addressed.

As this change gets under way, here are some of the concerns that have been put forward by a number of groups that came before this committee about who might be impacted and how we need to address that.

The Chair: Is there any debate? If there's none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? That does not carry.

Shall the preamble, as amended, carry? Those in favour? Those opposed? It does carry.

Shall the title of the bill carry? Those in favour? Those opposed? Carried.

Shall Bill 36, as amended, carry? Those in favour? Those opposed? Carried.

Shall I report the bill, as amended, to the House? Those in favour? Those opposed? Carried.

I thank you all for your participation. That's quite a bill. I think it will make quite a difference in Ontario. I didn't say which way.

The committee adjourned at 1235.

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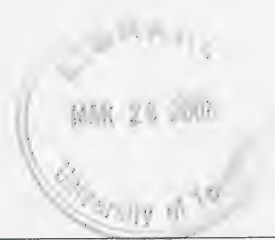
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Monday 20 February 2006

Journal des débats (Hansard)

Lundi 20 février 2006

Standing committee on social policy

Child and Family Services
Statute Law
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Comité permanent de la politique sociale

Loi de 2006 modifiant des lois
en ce qui concerne les services
à l'enfance et à la famille

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Monday 20 February 2006

Lundi 20 février 2006

*The committee met at 0935 in committee room 1.*CHILD AND FAMILY SERVICES
STATUTE LAW AMENDMENT ACT, 2006LOI DE 2006 MODIFIANT DES LOIS
EN CE QUI CONCERNE LES SERVICES
À L'ENFANCE ET À LA FAMILLE

Consideration of Bill 210, An Act to amend the Child and Family Services Act and make complementary amendments to other Acts / Projet de loi 210, Loi modifiant la Loi sur les services à l'enfance et à la famille et apportant des modifications complémentaires à d'autres lois.

The Chair (Mr. Mario G. Racco): Good morning and welcome. The order of business is Bill 210. We will start the clause-by-clause. The first amendment is from the NDP, and it's on page 1, if you would like to start with the amendment, please?

Ms. Andrea Horwath (Hamilton East): I move that paragraph 3 of subsection 1(2) of the Child and Family Services Act, as set out in section 1 of the bill, be amended by striking out "To recognize that children's services should be provided" at the beginning and substituting "To recognize that children's services must be provided."

The Chair: Are there any comments you wish to make on this motion? If there are no comments, I'll ask if there is any debate.

Mrs. Linda Jeffrey (Brampton Centre): The purpose of the act is to apply to all service providers under the act, including children's aid societies. Service providers must adhere to the paramount purpose of the act under section 1 to promote the best interests, protection and well-being of children. We believe the proposed amendment could have unintended consequences if the word "must" were used, and may create situations where the child's best interests, protection and well-being are not paramount, so we're going to be rejecting this amendment.

Ms. Horwath: I might as well put this on the table now. Many of the amendments I'm bringing forward are specifically recommended by many different groups, but particularly, we spent some time working on some of the First Nations' recommendations. This amendment was suggested by the First Nations communities as a way to strengthen the language in the act, not only to ensure that

the purposes of the legislation are understood and adhered to by service providers in terms of their import to First Nations, but also to other immigrant groups across the province. That was the purpose in putting it forward.

The Chair: Any further comments? If there are no further comments, then I will put the question. Shall the motion carry? Anyone in favour? Anyone opposed? The motion does not carry.

An NDP motion again, please, page 2.

Ms. Horwath: I move that subparagraph 3(i) of subsection 1(2) of the Child and Family Services Act, as set out in section 1 of the bill, be amended by adding "and cultural environment" at the end.

Not unlike the previous recommendation, this one is to reflect some of the issues raised by First Nations communities in regard to having the bill contain language that is respectful of their particular needs.

Mrs. Jeffrey: We believe the motion would make it clear that service providers should provide children's services in a manner that respects the child's cultural environment. We heard clearly from the Chiefs of Ontario and the native organizations that a child's cultural needs need to be protected. The government agrees that service providers should respect the child's cultural environment, and we support the amendment.

The Chair: Any further comments? If there are no more comments, I will put the question. Shall the motion carry? Those in favour? Those opposed? The motion carries.

Ms. Horwath, please, page 3.

Ms. Horwath: I have to ask a question of the clerk. I noticed, when I was reviewing these the other night, that there's a typo in the second-to-last line on that page. Where it says "spiritual and mental," it should say, "spiritual, mental and developmental needs." I don't know if I can read it into the record as it should be?

The Clerk of the Committee (Ms. Anne Stokes): If you'd like to read it in that way.

Ms. Horwath: I move that subparagraph 3(ii) of subsection 1(2) of the Child and Family Services Act, as set out in section 1 of the bill, be struck out and the following substituted:

"ii. takes into account physical, cultural, emotional, spiritual, mental and developmental needs and differences among children."

The Chair: Comments?

Mrs. Jeffrey: We believe the motion would expand the purposes of the act to make it clear that the provision of services to children should take into account the children's emotional, cultural and spiritual needs and differences. We accept and support the amendment, and we will withdraw government motion 4, which is substantially similar.

Mr. Jeff Leal (Peterborough): This is the great value of healing circles that are used extensively now in our First Nations communities. To have that enshrined is very important.

0940

The Chair: Any further debate? If there is no further debate, then I will put the question. Those in favour of the amendment? It carries.

Mrs. Jeffrey?

Mrs. Jeffrey: Number 4 is withdrawn.

The Chair: Number 4 is withdrawn. Number 5: Back to you, Madame Horwath, please.

Ms. Horwath: I move that subparagraphs 3(iii) and (iv) of subsection 1(2) of the Child and Family Services Act, as set out in section 1 of the bill, be struck out and the following substituted:

"iii. provides early, culturally appropriate assessment, planning and decision-making to achieve permanent plans for children that recognize their cultural identity in accordance with their best interests, and

"iv. includes the participation of a child, his or her parents and relatives and the members of the child's extended family and community."

The Chair: Any debate?

Mrs. Jeffrey: The government rejects the language in subparagraphs iii and iv. We believe the motion is unnecessary because the consideration of culture has been captured in NDP motions 2 and 3. Culture is only one of the components that is considered in a child's best interests. We believe it's unnecessary and that the motion fails to recognize that families should be included, where appropriate. There may be circumstances where it's not appropriate for safety reasons. So we can't support the amendment.

Ms. Horwath: There is one other point I want to make. This was suggested by First Nations communities, but also members of committee may recall some presentations from young women who had been through the system who indicated a frustration at lack of consultation with themselves, as their lawyers, the professionals, the social workers all participated in making plans for the children, particularly when they reached an age where they felt they had something to say about it, yet there was no opportunity for them to participate in these decision-making processes. So this is something that would also address that situation.

The Chair: Any debate? If there is no more debate, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Mrs. Jeffrey, please.

Mrs. Jeffrey: I move that subparagraph 3(iv) of subsection 1(2) of the Child and Family Services Act, as

set out in section 1 of the bill, be struck out and the following substituted:

"iv. includes the participation of a child, his or her parents and relatives and the members of the child's extended family and community, where appropriate."

The Chair: Any comments?

Mrs. Jeffrey: As it was stated on amendment 5, there may be circumstances where it's not appropriate, for safety reasons, for family to be included. The purposes of the act will make it clear that relatives, extended family and community members should be included in the provision of services to children, where appropriate. The best interests of the child are paramount. When it's appropriate, relatives, extended family and community members should be included in decision-making concerning any child.

The Chair: Any debate? If there is no more debate, I shall put the question. Those in favour of the motion? Opposed? It carries.

Shall section 1, as amended, carry? Those in favour? Those opposed? It carries.

Section 2: Ms. Horwath, please, page 7.

Ms. Horwath: I move that the definition of "extended family" in subsection 3(1) of the Child and Family Services Act, as set out in subsection 2(1) of the bill, be struck out and the following substituted:

"'extended family' means persons to whom a child is related by blood, through a spousal relationship, through adoption, through cultural affiliation or through ties to or affiliation with a band or native community; ('famille élargie')."

The Chair: Any debate?

Mrs. Jeffrey: The government rejects this amendment as we believe the intent to broaden the definition of "extended family" for native children is better captured in government motion 8. The government has broadened the definition of "extended family" in motion 8 and created a definition of "community."

Ms. Horwath: The only reason this is here, from our perspective, is that it's specifically the language that was suggested by a First Nations community, in that the addition of subsection (4) reflects the fact that the core community of a First Nations child is always his or her First Nation. Their community also includes clan relations. We tried to put "clan relations" into this motion but, unfortunately, legislative counsel determined that that was not appropriate language for the bill. I thought it was important to put that on the record.

The Chair: Any further debate? If there is none, I shall put the question. Those in favour of the motion? Opposed? It does not carry.

Ms. Jeffrey, please.

Mrs. Jeffrey: I move that the definition of "extended family" in subsection 3(1) of the Child and Family Services Act, as set out in subsection 2(1) of the bill, be struck out and the following substituted:

"'extended family' means persons to whom a child is related by blood, through a spousal relationship or through adoption and, in the case of a child who is an

Indian or native person, includes any member of the child's band or native community; ('famille élargie')."

The Chair: Any comments? If there are none, I shall put the question. Shall the motion carry? Those in favour? Opposed? It carries.

Ms. Horwath, please.

Ms. Horwath: I move that section 2 of the bill be amended by adding the following subsection:

"(4) Section 3 of the act is amended by adding the following subsection:

"(4) For the purposes of this act, the community of a child who is an Indian or native person includes all members of the child's band or native community and all persons who have ethnic, cultural or religious ties with the child or who have a beneficial or meaningful relationship with the child or with a parent, sibling or relative of the child."

The Chair: Any comments?

Mrs. Jeffrey: The government believes this amendment is unnecessary as the definition of "community" in section 2 of the bill is sufficiently broad to capture all persons with cultural ties to the child. Members of the child's band and native community are also included in the definition of "extended family" in the previous motion. We won't be supporting this amendment.

The Chair: Any further debate? Ms. Munro, please.

Mrs. Julia Munro (York North): Just really a legal question I wanted to raise on this, if I might, and that is the question of whether or not giving this kind of definition could be challenged by others who would then seek to use the same definition in their own cultural community.

Ms. Jeffrey: Mr. Chair, I would defer to staff to help us with that.

The Chair: It's more of a legal question, I guess. Is staff able to answer the question? Would you please have a seat? Thank you. If we can have your name, please, for the record.

Ms. Jennifer Gallagher: Jennifer Gallagher. I'm legal counsel with the Ministry of Children and Youth Services. Good morning. As I understand it, your question is, does the definition of "community" apply to other cultures within the community; is that correct?

Mrs. Munro: My question is whether or not it would open up to members of other cultural communities as a challenge to the exclusivity of this particular part of the bill.

Ms. Gallagher: Perhaps it would be helpful to understand the purpose of this particular definition. There are provisions in the bill which refer to placement of a child with community or extended family members. The intent of that is to place an emphasis on family and kith and kin for children. In fact, the definition of "community" is broad and would include any persons to which a child has a cultural tie or the child's parent or sibling.

Mrs. Munro: So this would apply, then, to non-native cultural communities?

Ms. Gallagher: Yes, it would.

Mrs. Munro: Thank you for the clarification.

The Chair: Any further debate? If there's none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 2, as amended, carry? Those in favour? Those opposed? That's carried.

Section 2.1: Ms. Horwath, please. Page 10.

Ms. Horwath: I move that the bill be amended by adding the following section:

"2.1. The act is amended by adding the following section:

"Children's aid society deemed to be governmental"—can I just ask, Mr. Chairman, again, the wording here; it should say "organization" and not "institution." So I don't know if it's appropriate if I just read it in as "organization."

The Chair: Yes, go ahead.

Ms. Horwath: Okay. Thank you.

"Children's aid society deemed to be governmental organization

"16.1 Despite the definition of 'governmental organization' in section 1 of the Ombudsman Act, every society is deemed to be a governmental organization for the purposes of that act."

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I think it's pretty clear that this particular motion is the one that our Ontario Ombudsman was interested in seeing included and one that New Democrats agree with in regard to the requirement for a completely separate oversight body to which complaints or concerns about children's aid societies can be raised. I know that the government has made attempts in amendments to this bill to cover that off through a completely different process. Unfortunately, it's not one that we support. We would like to see the Ombudsman have a clear role, like the Ombudsman's office does in many other provinces, that role of oversight and complaints review. So that's why this motion is here, to see that that be changed in the legislation so that we get that opportunity for families and children in Ontario as exists in many other provinces.

The Chair: Is there any debate?

Mrs. Jeffrey: Our government shares the Ombudsman's and the NDP's concern for the best interests of children within the child protection system. The Ombudsman has stated publicly that he believes clients of a children's aid society need to have an opportunity to bring their concerns forward to a neutral third party. We agreed. Children's aid societies must be accountable to the children and families that they serve. So what we've done is, the directors' reviews have been removed as part of the initial bill because they had been widely and heavily criticized. They were inconsistent, they were lengthy, they were not very arm's-length, and in the end they were non-binding. That's why we propose the use of the Child and Family Services Review Board, the CFSRB, to replace the current directors' reviews. The decisions under the CFSRB would be timely—they're going to have some strict timelines attached to them—neutral, binding and part of a standard, province-wide complaints process that's based on best practices.

The Ombudsman also stated that under Bill 210 the Ombudsman would lose the necessary oversight his office provides with the removal of directors' reviews. We have addressed this concern by proposing the use of the CFSRB, because as a government agency the Ombudsman would have authority over the CFSRB.

Although the Ombudsman has cited some tragic child deaths as areas he'd like to review, we need to remember that it is the role of the coroner's office to review deaths of children in care.

A letter sent to the committee—I believe everybody has a copy—by the chief coroner, Dr. James Cairns, makes a number of points, and among them is that the Office of the Chief Coroner conducts an external review in every situation where a child dies while being monitored by a children's aid society. The Ministry of Children and Youth Services is working with the coroner's office on an expedited basis to further strengthen the child death review process and, in turn, the accountability of children's aid societies.

We won't be supporting this motion.

The Chair: Ms. Horwath, please.

Ms. Horwath: I just wanted to make sure the record reflects that the concerns currently being brought to the Ombudsman's office in regard to children's aid societies are quite broad. So it's not just a matter of where there is a tragic incident of the death of a child. In fact, there are concerns about the care of the CAS, about the dealings that people have with the CAS.

Members of committee will recall a particular depuration from someone who is very frustrated about the lack of accountability and the lack of ability to have that person's concerns responded to in any fashion by the CAS. There are issues around threats of removal of children and sexual abuse by staff. There are a number of allegations that have already, in the last year, been brought to the Ombudsman's office, but of course the Ombudsman is not able to investigate those kinds of complaints.

So I think it's important to acknowledge and to have the record reflect that there is a broad range of concerns that the coroner's office would never be involved in, and that we think the complete, separate authority of the Ombudsman's office would have far more effective oversight ability than the internal operations that the government is looking to put in place with its procedure.

The Chair: Any further debate? If there is not, I shall put the question. Shall the motion carry? Those in favour? Those opposed? The motion does not carry.

Section 3: Shall section 3 carry? Those in favour? Those opposed? It carries.

Section 4: Ms. Horwath, page 11.

Ms. Horwath: I move that section 18 of the Child and Family Services Act, as set out in section 4 of the bill, be amended by adding the following subsections:

"Same, band and native community

"(2) An Indian or native child and family services authority designated under section 211 may appoint a person with the prescribed qualifications and that person

shall have all the powers of a local director under subsection (1) for the purpose of designating places as places of safety for the purposes of the band or native community for which the authority was designated.

"Same

"(3) If an Indian or native child and family services authority has not been designated for a band or native community, the band or native community may appoint a person for the purposes of subsection (2)."

The Chair: Any debate?

Mrs. Jeffrey: We believe this amendment is unnecessary. It's unnecessary for the native child and family services authority to be designated as a local director, because they can be given the authority to assess homes as a place of safety without appointing them as local directors. In section 6 of the act, there is a government motion 19 which clarifies this issue and permits a body designated as a native child and family services authority to conduct assessments of a community home to determine if the home may be deemed a place of safety. Therefore, we reject this amendment.

Ms. Horwath: If I can, this was something that was recommended by First Nations communities, and it reflects their frustration with the timeliness of current processes. Therefore, they're suggesting that this language be included to allow for a more expedited approvals process for homes on reserve.

The Chair: Any further debate? If there's no further debate, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 4 carry? Those in favour? Those opposed? It carries.

Section 5: Ms. Horwath, page 12, please.

Ms. Horwath: I move that section 20.2 of the Child and Family Services Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Where child is Indian or native person

"(1.1) If the issue referred to in subsection (1) relates to a child who is an Indian or native person, the society shall consult with the child's band or native community to determine whether an alternative dispute resolution process established by that band or native community or another prescribed process will assist in resolving the issue."

Again, this was recommended by the First Nations community. Their rationale is around the entry into a First Nations-established alternative dispute resolution process, which can lead to early resolution of disputes, more meaningful involvement of parents, relatives and extended family members, and increased compliance for protection plans and lower costs. From their perspective, this language ensures that First Nations types of ADR are utilized.

The Chair: Any debate?

Mrs. Jeffrey: We believe this amendment is substantially similar to government motion 13. We can accept it and support it, and I'm happy to withdraw number 13.

The Chair: Thank you. Mrs. Munro, please.

Mrs. Munro: Coming back to an earlier conversation from legal counsel with regard to the application of the other communities that might seek a similar kind of definition, I'm just wondering whether or not, in an amendment such as this, it would seem to follow logically that someone else, another cultural community, could take the same position being suggested here. I wonder if we could have that clarification.

Ms. Gallagher: The amendment related to the definition of "community." I could advise that the definition of "community" is already sufficiently broad to capture persons who have an ethnic or cultural tie to a child. Other cultures would already have the same ability to be considered persons within a child's community.

Mrs. Munro: That's fine. My question, then, is simply the extension of that, so that in considering amendments such as the one we are considering, the same kind of environment, if you like, would exist for those communities that would fall under the inclusion of the definition that we already agreed on.

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Ms. Gallagher: The definition of "community."

Mrs. Munro: That's right, because if you look at this amendment that we're currently considering, it suggests here that "the society shall consult with the child's band or native community." If we've assumed the ability to transfer that in the definition at the beginning, my question then is simply, does it carry over into these other areas of the bill?

Ms. Gallagher: I'm sorry. I've misunderstood your question. No. In fact, this particular amendment is specific to where a child is an Indian or native person. With respect to the particular amendments here, which refer to where a child is an Indian or a native person the society shall do the following, those particular provisions would only apply to native children. The act has a number of aboriginal-specific provisions, and I would suggest that these provisions simply build on those that already exist.

Mrs. Munro: I just wanted for people to be clear about when a community is defined specific to a native community and when it's a different cultural community. I think it's important for us to understand that those are two different groups.

Ms. Gallagher: That's correct. I misunderstood your question; I apologize. "Native community" is in fact defined within the Child and Family Services Act. They are communities that have been designated as native communities, so it is specific. That's different than "community."

Mrs. Munro: Okay. it's just that in here there's reference to "community," so I wanted to be sure there was that understanding.

The Chair: Any further debate? If there's none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Mrs. Jeffrey, number—

Mrs. Jeffrey: We're withdrawing.

The Chair: You're withdrawing page 13.

Back to you, Ms. Horwath: page 14, please.

Ms. Horwath: If I can just preface my reading in of this motion, I understand that the government's got another motion that's going to take into consideration very much similar language. I'd really like to read this one in—even though I understand it's not quite the same, but it's going to be very similar to the one that the government is going to put forward—because I think it's important that section B at least be put on the record. Again, it's just being sensitive to the language that builds on the needs of First Nations communities in terms of having their desires or their concerns put forward in the process. Again, it's not so much the substantive issue, but more the process issue and respecting their desire to have their voice at this process. That's why I'm going to continue to put it forward, although I understand completely that the government will be putting forward their own motion that builds most of these issues in.

I move that subsection 20.2(2) of the Child and Family Services Act, as set out in section 5 of the bill, be amended by,

"(a) striking out 'that a prescribed method of alternative dispute resolution be undertaken' and substituting 'that a method of alternative dispute resolution that is prescribed or approved by a band or native community be undertaken'; and

"(b) striking out 'legal representation' and substituting 'culturally competent legal representation.'"

The Chair: Is there any debate?

Mrs. Jeffrey: We require some additional wording to make it clear that young people may retain their own lawyers outside the Office of the Children's Lawyer if they wish. We had hoped we would be able to find a compromise and we would have withdrawn motion 15, but as we can't do that, we'll be voting against this amendment.

The Chair: I think the arguments have been made. Any more debate? If there's none, I'll take the vote. Those in favour of the amendment? Those opposed? It does not carry.

Mrs. Jeffrey, please.

Mrs. Jeffrey: I move that subsection 20.2(2) of the Child and Family Services Act, as set out in section 5 of the bill, be struck out and the following substituted:

"Children's Lawyer

"(2) If a society or a person, including a child, who is receiving child welfare services proposes that a prescribed method of alternative dispute resolution be undertaken to assist in resolving an issue relating to a child or a plan for the child's care, the Children's Lawyer may provide legal representation to the child if in the opinion of the Children's Lawyer such legal representation is appropriate."

The Chair: Any debate? If there is none, I will then put the question. Shall the motion carry? Those in favour? Those opposed? The motion carries.

Mrs. Jeffrey, number 16.

Mrs. Jeffrey: I move that section 20.2 of the Child and Family Services Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Notice to band, native community

"(3) If a society makes or receives a proposal that a prescribed method of alternative dispute resolution be undertaken under subsection (2) in a matter involving a child who is an Indian or native person, the society shall give the child's band or native community notice of the proposal."

In plain language, this motion would require children's aid to give notice of a proposal for alternative dispute resolution. It's substantially similar to motion 17 of the NDP.

We clearly heard from the Chiefs of Ontario and the native organizations that providing notification to First Nations and including the participation of band representatives enable First Nations to provide culturally appropriate support and input into the dispute process. The government believes that First Nations representatives need to be aware of any efforts to resolve matters, whether they're before a court or through alternative dispute resolution.

The Chair: Any debate? If there is none, then I will put the question. Shall the motion carry? Those in favour? Those against? It carries.

Ms. Horwath, motion 17.

Ms. Horwath: Motion 17 is still in order, then, Mr. Chairman?

The Chair: Unless staff tells me otherwise, I believe it is, yes.

Ms. Horwath: I move that section 20.2 of the Child and Family Services Act, as set out in section 5 of the bill, be amended by adding the following subsection:

"Band representation

"(4) If an alternative dispute resolution process is utilized in a matter concerning a child who is an Indian or native person and is or may be in need of protection, the society shall give notice to the child's band or native community and the band or native community may appoint a representative to participate in the process."

The Chair: Any comments?

Ms. Horwath: The concern has been where there are not agencies designated already. We heard concern from First Nations communities about being able to have processes take place in a timely fashion. What this does is provide the opportunity for that to happen through band representation.

The Chair: Is there any debate on page 17? If there is none, I'll put the question. Those in favour of the motion? Those opposed? It does not carry.

Therefore, we'll take a vote on the section, as amended. Shall section 5, as amended, carry? Those in favour? Those opposed? It carries.

Section 6, page 18, Mrs. Jeffrey.

Mrs. Jeffrey: I move that paragraph 6 of subsection 37(3) of the Child and Family Services Act, as set out in subsection 6(3) of the bill, be struck out and the following substituted:

"6. The child's relationships and emotional ties to a parent, sibling, relative, other member of the child's extended family or member of the child's community."

We heard very compelling testimony from a lot of young people who appeared before this standing committee that sibling relationships are particularly important to children and youth receiving child welfare services. In cases where children are removed from their parents' care, the loss they feel is obviously very profound. This is compounded when the separation of siblings occurs. Any plan proposed through a court needs to consider, in light of the child's best interests, how to include a sibling in the process.

The Chair: Any debate? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Page 19, Mrs. Jeffrey.

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Mrs. Jeffrey: I move that subsection 37(5) of the Child and Family Services Act, as set out in subsection 6(4) of the bill, be struck out and the following substituted:

"Place of safety

"(5) For the purposes of the definition of 'place of safety' in subsection (1), a person's home is a place of safety for a child if,

"(a) the person is a relative of the child or a member of the child's extended family or community; and

"(b) a society or, in the case of a child who is an Indian or native person, an Indian or native child and family services authority designated under section 211 of part X has conducted an assessment of the person's home in accordance with the prescribed procedures and is satisfied that the person is willing and able to provide a safe home environment for the child."

In the past, where aboriginal children were removed from their homes for protection reasons, they were frequently removed to a place in a non-native home, away from their family and their community members. I think we heard that eloquently from the witnesses we saw. We believe that the First Nation child and family services agency knows more intimately the members of the community and can determine that a home is safe by following the requirements for approving a home.

Immediate placement with extended family or community members will reduce the fear and anxiety children experience and promote cultural continuity.

The Chair: Any debate on the motion? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Ms. Horwath, page 20, please.

Ms. Horwath: I move that subsection 37(5) of the Child and Family Services Act, as set out in subsection 6(4) of the bill, be amended by striking out "and" at the end of clause (a), by adding "and" at the end of clause (b) and by adding the following clause:

"(c) if the child is an Indian or native person, the person appointed to designated places of safety under subsection 18(2) or (3) for the child's band or native community has conducted an assessment of the person's home in accordance with the procedures established by the band or native community and is satisfied that the

person whose home is assessed is willing and able to provide a safe home environment for the child.”

Mr. Chairman, if I can, this is a way to—

The Chair: I’m sorry. If I may, it seems to me that this motion is redundant. We have already addressed what you’re trying to address on this page. I wonder if you agree with me and, if so, maybe you want to withdraw that motion.

Ms. Horwath: That’s because the previous government motion covered off the same issues?

The Chair: That’s right. Are you satisfied? We have two choices. We can leave it as out of order or you can withdraw, whichever you prefer, unless you disagree, and then I’ll ask staff to assist us.

Ms. Horwath: I understand that it’s the same piece, but I would rather leave it as a ruling because at least reading it into the record I think is important. The language is that which was provided by First Nations communities and is very specific to the cultural sensitivity around who decides whether the home is a safe place. That’s reflected in the motion I have brought forward. If you are going to rule against it as out of order, that’s fine.

The Chair: So we’ll do that. I’ll rule it out of order. It stays on the table.

We basically have addressed section 6 so we’re going to take a vote. Shall section 6, as amended, carry? Those in favour? Against? It carries.

We’ll move on to section 7. No amendments, so shall section 7 carry? Those in favour? Those opposed? It carries.

Section 8: Ms. Horwath, page 21, please.

Ms. Horwath: I move that subsection 51(3.1) of the Child and Family Services Act, as set out in subsection 8(3) of the bill, be struck out and the following substituted:

“Placement with relative, etc.

“(3.1) Before making a temporary order for care and custody under clause (2)(d), the court shall consider,

“(a) whether it is in the child’s best interests to make an order under clause (2)(c) to place the child in the care and custody of a person who is a relative of the child or a member of the child’s extended family or community; and

“(b) the availability of financial support and services for the care of the child if the child is placed in the care and custody of a person who is a relative of the child or a member of the child’s extended family or community.”

The Chair: Any comments?

Ms. Horwath: It’s pretty clear. What this does is allow for financial support and services for children who are placed in temporary kinship care. We came forward with this amendment and then found that First Nations also were interested in a similar amendment.

The Chair: Any debate?

Mrs. Jeffrey: We believe the motion is unnecessary. A court has the responsibility to look at any plan to determine if it is in the child’s best interest. This includes the availability of supports and services. The government is concerned that the proposed amendment may have

unintended consequences if it results in a reluctance to participate in a plan for a child because the court must scrutinize the finances of the proposed caregiver. So we will not be supporting this motion.

Ms. Horwath: If I can, part of the building in of this now is to provide a foundation for the fact that we’re also putting amendments that ask to ensure that government support is there when financial support from the family is not there. So again, this is a principle of financial support that we will build on in future amendments in regard to having some guarantees or commitments from CASs that their extended care and maintenance agreements and their financial supports could be built in when there are arrangements being made.

Mrs. Jeffrey: I hear what the NDP is telling us, and I think funding policies are being developed so that agencies can provide appropriate support to families. It’s something we clearly heard from our witnesses and it’s something we took very seriously.

Ms. Horwath: If I can follow up, the only thing we wanted to be sure of is—I spoke to the minister and appreciated her explanation of how those issues will be addressed outside of legislation, but we believe that building those principles into legislation strengthens those principles and helps us to ensure that, whether it’s this government or some government in the future, the requirements are still enshrined in law.

The Chair: Any further debate? If there’s none, I shall put the question. Those in favour of the amendment? Those opposed? That does not carry.

The next page, back to you, page 22.

Ms. Horwath: I move that clause 51(3.2)(c) of the Child and Family Services Act, as set out in subsection 8(3) of the bill, be amended by striking out “but shall not require the society to provide financial assistance or to purchase any goods or services” at the end and substituting “and may require the society to provide financial assistance or goods or services if it would be in the best interests of the child.”

That’s just reflective of the previous debate.

The Chair: Any debate?

Mrs. Jeffrey: Not debate, but I guess agreement. The motion would permit the court to impose financial obligations on a CAS. Bill 210 is just one component of a larger child welfare transformation initiative. Greater supports, including financial supports, are most appropriately addressed through policy, not legislation, and funding policies are being developed. We said we’d like to see more children placed with somebody they know and trust like a grandparent or an aunt or an uncle. In these cases, supports would be needed to make the placement viable and sustainable and we recognize that. But we won’t be supporting this motion.

The Chair: Any further debate? If there is none, I shall put the question. Shall the motion carry? Those in favour? Opposed? It does not carry.

No change to the section, so shall section 8 carry? Those in favour? Those opposed? That’s carried.

Shall section 9 carry? Those in favour? Those opposed? It carries.

Section 10, Ms. Horwath, page 23.

Ms. Horwath: I move that subsection 54(1) of the Child and Family Services Act, as set out in subsection 10(1) of the bill, be struck out and the following substituted:

“Order for assessment

“(1) The court may make an order, based on the evidence presented and in accordance with the regulations, that one or more of the following persons attend and undergo a culturally appropriate assessment within a specified time:

“1. The child.

“2. A parent of the child.

“3. Any other person who is putting forward or would participate in a plan for the care and custody of or access to the child.

“Same

(1.0.1) An assessment referred to in subsection (1) shall be conducted by a person,

“(a) who is qualified to perform medical, emotional, developmental, psychological, educational or social assessments;

“(b) whom the parties agree is qualified to conduct the assessment in a culturally sensitive manner; and

“(c) who consents to perform the assessment.”

From a First Nations perspective, it was essential that it be made clear in law that any assessment instrument used is culturally appropriate—that’s language you’ll notice I’ve had in previous recommended amendments—and that the assessment be conducted by a person or persons qualified and able to complete that assessment, again in a culturally sensitive manner. In addition, the court would have the ability, where there is any concern, to order the foster parent or prospective foster parent to attend and undergo a relevant assessment.

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The Chair: Any debate?

Mrs. Jeffrey: This motion would remove the authority of the courts to approve and assess where the parties can’t agree. It’s important, we believe, for the courts to retain that authority to compel a party to participate in an assessment. The cultural competence of an assessor can be considered by the parties when they have an opportunity to agree upon an assessor. We believe government motion 24 will provide for that. The court currently does not have authority to order a foster parent to participate in an assessment. This motion could have the unintended consequence of discouraging recruitment and retention of foster parents, so we won’t be supporting it.

The Chair: Any further debate? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Mr. Craitor?

Mr. Kim Craitor (Niagara Falls): Thank you, Mr. Chair. I’m pleased to read in the following motion:

I move that subsections 54(1) and (1.1) of the Child and Family Services Act, as set out in subsection 10(1) of the bill, be struck out and the following substituted:

“Order for assessment

“(1) In the course of a proceeding under this part, the court may order that one or more of the following persons undergo an assessment within a specified time by a person appointed in accordance with subsections (1.1) and (1.2):

“1. The child.

“2. A parent of the child.

“3. Any other person, other than a foster parent, who is putting forward or would participate in a plan for the care and custody of or access to the child.

“Assessor selected by parties

“(1.1) An order under subsection (1) shall specify a time within which the parties to the proceeding may select a person to perform the assessment and submit the name of the selected person to the court.

“Appointment by court

“(1.2) The court shall appoint the person selected by the parties to perform the assessment if the court is satisfied that the person meets the following criteria:

“1. The person is qualified to perform medical, emotional, developmental, psychological, educational or social assessments.

“2. The person has consented to perform the assessment.

“Same

“(1.3) If the court is of the opinion that the person selected by the parties under subsection (1.1) does not meet the criteria set out in subsection (1.2), the court shall select and appoint another person who does meet the criteria.

“Regulations

“(1.4) An order under subsection (1) and the assessment required by that order shall comply with such requirements as may be prescribed.”

The Chair: Any comments?

Mrs. Jeffrey: In practice, studies have shown that where there is agreement on who will perform the assessment, all parties are more satisfied with the process of an assessment. We heard clearly from the aboriginal leaders who came here to see us, who expressed concern about the cultural competence, as Ms. Horwath talked about previously, of court-ordered assessments and a lack of input regarding who should be deemed appropriate to perform an assessment of an aboriginal child or family.

This motion would allow the parties a time frame to select an assessor. Each party would be able to consider and express their wishes regarding who should perform the assessment. We hope the ability to select an assessor will lead to a more meaningful participation in the assessment and a greater acceptance of the assessor’s recommendations to the court.

The Chair: Any debate?

Ms. Horwath: Can I ask a question? Under “Assessor selected by parties,” (1.1)—that’s the part of this amendment that the government is indicating will cover off the requirements for the assessor to be culturally appropriate for First Nations communities? Is that right?

The Chair: Mr. Craitor or Mrs. Jeffrey? Whom would you like to answer that question? Maybe staff?

Mrs. Jeffrey: A lawyer, probably, could answer this better than I could.

The Chair: Staff, please.

Ms. Gallagher: What subsection (1.1) will permit is the opportunity for the parties, within a specified time frame, to agree upon an assessor. That gives the parties an opportunity to put forward persons that they deem to be culturally competent. Hopefully, parties will be able to agree, and that assessor would be selected. In the event that the parties are unable to agree to an assessor, the court would have the authority to appoint a person.

Ms. Horwath: I recall having heard concerns from First Nations communities and leaders about the frustrations they have with the processes that sometimes mean that they miss deadlines because the information isn't flowing in a direct manner, particularly with the lack of designated agencies that they have in their communities.

I get concerned that these kinds of amendments or that this kind of solution, if you will, is still going to run up against some of those procedural concerns that we heard from First Nations communities and will end up in a situation where, in fact, because communication hasn't flowed in appropriate channels or there wasn't a designated person or there's no agency, they're not going to be able to achieve what is in this amendment in terms of having a culturally appropriate assessment.

I just want to put on the record that although I understand what this is attempting to do, I'm not sure, with the rest of the concerns that we heard, that we're not going to end up in the same situation. I would hope that doesn't happen, but I do have some concerns remaining.

The Chair: Any further debate?

Mrs. Jeffrey: Not debate, but more of a comment. We realize we're breaking new ground. I think the First Nations community asked for this and wanted to be included and to have the ability to choose and make choices about their own community. My guess is that this is going to be challenging for them to achieve, but I have every confidence they'll be able to do it, with some effort.

Ms. Horwath: I would agree, except that I think success is going to come with more supports from government as well in terms of making sure that resources are available to build in those successes.

The Chair: If there's no more debate, I will now put the question. Shall the motion carry? Those in favour? Those opposed? The motion does carry.

Shall section 10, as amended, carry? Those in favour? Those opposed? The section carries.

Shall section 11 carry? Those in favour? Those opposed? It carries.

Section 12; Ms. Horwath, page 25.

Ms. Horwath: I move that section 12 of the bill be amended by adding the following subsection:

"(2) Section 56 of the act is amended by adding the following subsection:

"Consideration of other plans submitted by parties

"(2) The court shall, before making an order under section 57, 57.1, 65 or 65.2, consider any plan for the

child's care and custody that is prepared by a parent of the child or by a person who would participate in the plan."

This is something that was raised by First Nations communities. Their concern is that the act should recognize alternatives to the society's plans, that those alternatives may be submitted by other parties and at least should be considered in the process. Again, this is something that they raised themselves and brought forward as a way of seeing whether that might be possible.

1030

The Chair: Any comments? Yes, Linda.

Mrs. Jeffrey: Mr. Chair, we feel this motion is unnecessary as there is already a requirement under the family law rules for a person who is putting forth a plan to submit a written plan of care. So we won't be supporting the motion.

The Chair: Okay. Any further debate or comments? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Jeffrey, page 26.

Mrs. Jeffrey: I move that section 12 of the bill be amended by adding the following subsection:

"(2) Section 56 of the act is amended by striking out 'and' at the end of subclause (d)(ii), by adding 'and' at the end of clause (e) and by adding the following clause:

"(f) a description of the arrangements made or being made to recognize the importance of the child's culture and to preserve the child's heritage, traditions and cultural identity."

The rationale for this is that families and children need assurances that a child's cultural identity and development will be adequately addressed in any plan of their care. Aboriginal leaders clearly expressed concern that for Indian and native children far too little attention has been given to providing culturally appropriate placements and plans for children. This requirement would appropriately focus the attention of the society on the cultural needs of children and provides the oversight of the court to scrutinize those efforts and plans made to meet these important needs.

The Chair: Any comments or debate? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 12, as amended, carry? Those in favour? Those opposed? Carried.

Section 13; Ms. Jeffrey, page 27.

Mrs. Jeffrey: Ms. Wynne.

Ms. Kathleen O. Wynne (Don Valley West): I move that clause 57(8)(b) of the Child and Family Services Act, as set out in subsection 13(5) of the bill, be struck out and the following substituted:

"(b) reasonable terms and conditions on,

"(i) the child's parent,

"(ii) the person who will have care and custody of the child under the order,

"(iii) the child, and

“(iv) any other person, other than a foster parent, who is putting forward or would participate in a plan for the care and custody of or access to the child; and.”

The Chair: Comments?

Mrs. Jeffrey: This amendment is proposed so that the court can maintain its current authority to impose terms and conditions on the child. As this was inadvertently omitted from the list, this is a housekeeping amendment.

Ms. Horwath: We have an amendment as well. The biggest difference, from what I can figure, is that ours includes requirements for financial assistance on purchase of goods and services “as may be necessary to ensure the success of the placement.”

I’m just anticipating the same thing happening again, which is that the government motion is going to pass and mine is going to be ruled out of order—saving us all that trouble.

We thought it was important. In fact, there was a First Nations recommendation as well that the court’s authority should be expanded so terms and conditions can be ordered that relate to the child’s care or to a person who is putting forward a plan or who would participate in a plan for care and custody of or have access to the child. But the court should also be able to impose reasonable conditions on a foster parent and require financial assistance and/or goods and services to be provided if deemed necessary to ensure the success of the placement.

Again, this is all about making sure that children have some stability in their placements and that we do everything possible to make sure those placements are successful, including financial requirements. I’ll leave it at that.

The Chair: Thanks. Any further comments or debate? If there is none, I will put the question. Shall the motion carry? Those in favour? Those against? The motion carries.

Of course, there’s your motion. Do you want to put it on the record, and then we will—

Ms. Horwath: I’ll have to withdraw 28.

The Chair: You will withdraw it. Okay, good. Thank you.

Therefore, shall section 13, as amended, carry? Those in favour? Those opposed? It carries.

Section 14: page 29, Ms. Wynne.

Ms. Wynne: I move that section 57.1 of the Child and Family Services Act, as set out in section 14 of the bill, be amended by adding the following subsections:

“Order restraining harassment

“(2.1) When making an order under subsection (1), the court may, without a separate application under section 35 of the Children’s Law Reform Act,

“(a) make an order restraining any person from molesting, annoying or harassing the child or a person to whom custody of the child has been granted; and

“(b) require the person against whom the order is made to enter into such recognizance or post such bond as the court considers appropriate.

“Same

“(2.2) An order under subsection (2.1) is deemed to be a final order made under section 35 of the Children’s

Law Reform Act and may be enforced, varied or terminated only in accordance with that act.”

The Chair: Any comments?

Mrs. Jeffrey: Any permanent plan for the care of a child or youth must provide for their safety, permanence and well-being. Providing a restraining order at the same time as the custody order is made streamlines the court processes and ensures there will not be a gap between the custody order and the restraining order. That’s what this motion is designed to achieve.

The Chair: Are there any comments or debate? If there are none, I will put the question. Shall the motion carry? Those in favour? Those against? It carries.

Page 30.

Mrs. Jeffrey: I move that subsection 57.1(3) of the Child and Family Services Act, as set out in section 14 of the bill, be struck out and the following substituted:

“Appeal under section 69

“(3) Despite subsections (2) and (2.2), an order under subsection (1) or (2.1) and any access order under section 58 that is made at the same time as an order under subsection (1) are orders under this part for the purposes of appealing from the orders under section 69.”

This amendment is a housekeeping amendment. It’s to deal with an appeal of orders and should remain under the Child and Family Services Act, given that the orders are made under this act.

The Chair: Any debate? Any comments? If there’s none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Shall section 14, as amended, carry? Those in favour? Those opposed? It carries.

Section 15: page 31.

Mr. Craitor: I move that section 57.2 of the Child and Family Services Act, as set out in section 15 of the bill, be amended by striking out “If a proceeding is commenced under this part” at the beginning and substituting “If, under this part, a proceeding is commenced or an order for the care, custody or supervision of a child is made.”

The Chair: Any comments?

Mrs. Jeffrey: This is another housekeeping motion. This section makes it clear that where there are protection proceedings or a protection order been made related to a child, any proceeding under the Children’s Law Reform Act regarding the child cannot proceed unless the court gives permission.

The Chair: Any comments? If there are none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 15, as amended, carry? Those in favour? Those opposed? It does carry.

Shall section 16 carry? Those in favour? Those opposed? It carries.

Section 17: Ms. Horwath, page 32.

Ms. Horwath: I move that clause 59(2.1)(b) of the Child and Family Services Act, as set out in subsection 17(2) of the bill, be struck out and the following substituted:

“(b) the ordered access will not impair the child’s future opportunities for a permanent or stable placement.”

If I may, this amendment was requested by Legal Aid Ontario, who argued during the hearings that the current wording—“adoption”—rather than what we have here—“permanent or stable placement”—imposed too great a restriction on the courts when considering whether or not to vary access orders. They felt that that would be a barrier to adoption and placement, and since we’re kind of trying to do the opposite with this bill, we thought that changing that language might be helpful.

The Chair: Any debate?

Mrs. Jeffrey: This motion reverts to the current wording in the Child and Family Services Act, and we believe that the current wording is not sufficient to ensure that a crown ward will be eligible for adoption where adoption is deemed to be the best plan. The intent of the government is to increase the number of crown wards eligible for adoption where adoption is the appropriate plan for the child.

The changes proposed in Bill 210 make it clear that access should not be ordered in cases where adoption is the appropriate plan, and where adoption is the plan, contact or communication between the child and a member of the child’s family or community can be accomplished through an openness order or an openness agreement.

The Chair: Any debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: page 33.

1040

Ms. Horwath: I move that section 17 of the bill be amended by adding the following subsection:

“(5) Section 59 of the act is amended by adding the following subsection:

““Indian or native child

“(5) Despite subsection (4), if a crown ward is an Indian or native child, the society shall permit contact or communication between the child and members of the child’s band or native community.”

The Chair: Any comments or any debate?

Mrs. Jeffrey: The government feels this amendment is too broad. It may not be in the child’s best interest to have contact with any member of the band as there may be safety concerns. It’s really important that the child’s wishes be considered. Therefore, we cannot support the motion.

The Chair: Any further debate? If there is none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 17 carry? Those in favour? Those opposed? Carried.

Section 18: Ms. Horwath, page 34.

Ms. Horwath: I move that section 59.1 of the Child and Family Services Act, as set out in section 18 of the bill, be amended by adding the following subsection:

“May request assistance of the society in subsequent proceeding

“(2) A person who has custody of a child pursuant to an order made under section 57.1 may request the assistance of the society and the society shall provide assistance if,

“(a) the person who has custody of the child wants to bring an application under section 21 of the Children’s Law Reform Act to vary or terminate an order for access to the child that was made under section 58 at the same time as the custody order; or

“(b) another person brings an application under section 21 of the Children’s Law Reform Act or under section 58 for an order permitting that person’s access to the child.”

Again, this is something that we brought forward on the recommendation or the request of First Nations communities. Their concern is the—am I reading the right one? I’m not sure if I’ve got the right note in front of me, now that I look at my notes here. Here it is: A person assuming custody as a result of a child welfare proceeding should be able to expect assistance, if requested, from the society that was involved in the case, in any effort made by a person denied access at the time of the custody order to subsequently regain access, or in any effort to secure an order denying access post-custody.

The Chair: Any debate?

Mrs. Jeffrey: The government feels the children’s aid society should only [*failure of sound system*] concerns. If there are protection concerns in any case, the referral can be made to a children’s aid society. We will not be supporting the motion.

The Chair: Any further debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 18 carry? Those in favour? Those opposed? Carried.

Section 19: Ms. Horwath, page 35.

Ms. Horwath: I move that subsection 61(7) of the Child and Family Services Act, as set out in subsection 19(2) of the bill, be struck out and the following substituted:

“Notice of proposed removal

“(7) Where a child is a crown ward and has lived continuously with a foster parent for two years, the society shall not remove the child under subsection (6) without,

“(a) giving the foster parent 10 days’ notice in writing of the proposed removal and of the foster parent’s right to apply for a review under subsection (7.1); and

“(b) if the child is an Indian or native person, giving a representative chosen by the child’s band or native community 10 days’ notice in writing of the proposed removal.”

Again, this is brought forward on behalf of First Nations communities who say that just as provision is made in the act for First Nations to be notified and to participate in the decision-making around the initial placement of the child, provisions should be provided for participation in actions surrounding the removal of the

child from a placement and subsequent placement in another home.

The Chair: Any debate?

Mrs. Jeffrey: The government believes this motion doesn't quite put in place the necessary detailed processes. We believe the government motion to be more comprehensive because it includes additional safeguards. Government motion 36 also provides additional provisions in which consultation with a child's band or native community would occur. The government motion also includes the notice provisions and gives the band or the native community party status where a hearing is being held. As well, motion 36 provides for a hearing before the Child and Family Services Review Board. Therefore, we cannot support this motion.

The Chair: Any debate? If there's none, I'll put the question. Shall the motion carry? Those in favour? Opposed? It does not carry.

The Chair: Ms. Wynne: 36, please.

Ms. Wynne: I move that subsections 61(7), (7.1) and (8) of the Child and Family Services Act, as set out in subsection 19(2) of the bill, be struck out and the following substituted:

"Notice of proposed removal

"(7) If a child is a crown ward and has lived continuously with a foster parent for two years and a society proposes to remove the child from the foster parent under subsection (6), the society shall,

"(a) give the foster parent at least 10 days' notice in writing of the proposed removal and of the foster parent's right to apply for a review under subsection (7.1); and

"(b) if the child is an Indian or native person,

"(i) give at least 10 days' notice in writing of the proposed removal to a representative chosen by the child's band or native community, and

"(ii) after the notice is given, consult with representatives chosen by the band or community relating to the plan for the care of the child.

"Application for review

"(7.1) A foster parent who receives a notice under clause (7)(a) may, within 10 days after receiving the notice, apply to the board in accordance with the regulations for a review of the proposed removal.

"Board hearing

"(8) Upon receipt of an application by a foster parent for a review of a proposed removal, the board shall hold a hearing under this section.

"Where child is Indian or native person

"(8.1) Upon receipt of an application for review of a proposed removal of a child who is an Indian or native person, the board shall give a representative chosen by the child's band or native community notice of receipt of the application and of the date of the hearing.

"Practices and procedures

"(8.2) The Statutory Powers Procedure Act applies to a hearing under this section and the board shall comply with such additional practices and procedures as may be prescribed.

"Composition of board

"(8.3) At a hearing under this section, the board shall be composed of members with the prescribed qualifications and prescribed experience.

"Parties

"(8.4) The following persons are parties to a hearing under this section:

"1. The applicant.

"2. The society.

"3. If the child is an Indian or a native person, a representative chosen by the child's band or native community.

"4. Any person that the board adds under subsection (8.5).

"Additional parties

"(8.5) The board may add a person as a party to a review if, in the board's opinion, it is necessary to do so in order to decide all the issues in the review.

"Board decision

"(8.6) The board shall, in accordance with its determination of which action is in the best interests of the child, confirm the proposal to remove the child or direct the society not to carry out the proposed removal, and shall give written reasons for its decision.

"No removal before decision

"(8.7) Subject to subsection (9), the society shall not carry out the proposed removal of the child unless,

"(a) the time for applying for a review of the proposed removal under subsection (7.1) has expired and an application is not made; or

"(b) if an application for a review of the proposed removal is made under subsection (7.1), the board has confirmed the proposed removal under subsection (8.5)."

The Chair: Any comments?

Mrs. Jeffrey: We believe that in appropriate cases, a review of society decisions should occur before a neutral third party. That's why we've introduced the Child and Family Services Review Board. Decisions under the CFSRB would be timely, neutral and binding. Through notice of participation, the band can promote consideration and preservation of a child's cultural community connections.

Mrs. Munro: I'm glad that you refer to the importance of timely decisions. There are other similar kinds of boards that do have very prescriptive indicators of timeliness. Given the delicacy of the situations that this board would be dealing with, I think this might be an opportunity, if it isn't somewhere else, to indicate what kind of timeliness you're talking about.

I would also suggest that it has become practice in many other pieces of legislation to look at 10 business days. Those two issues around timeliness—I'd appreciate a response from you on it.

Mrs. Jeffrey: Maybe I could ask staff to clarify "timeliness"?

Mr. Bruce Rivers: Bruce Rivers, Child Welfare Secretariat. The 10 days are 10 calendar days, not 10 business days. Also, aside from the 10 days within which the foster parent must express their concern about the plan, there will then be conditions through regulation that

will apply to all other steps of the complaint process, including the time within which the board must respond to the complaint.

Mrs. Munro: Thank you. I think it's really important that those kinds of safeguards are there.

The Chair: Any further debate? If there is none, I shall put the question: Shall the motion carry? It carries.

Page 37: Ms. Horwath, please.

Ms. Horwath: Mr. Chairman, I might be wrong, but I think both of the next two items are in reference to the government motion that was just passed.

1050

The Chair: You're referring to both 37 and 38?

Ms. Horwath: Yes. So there's really no need for these, because they've been incorporated in the motion that we all just supported. So I would just withdraw 37 and 38.

The Chair: Thank you. Page 39: Mrs. Jeffrey.

Mrs. Jeffrey: I move that subsection 19(3) of the bill be struck out and the following substituted:

“(3) Subsection 61(9) of the act is repealed and the following substituted:

“Where child at risk

“(9) A society may remove the child from the foster home before the expiry of the time for applying for a review under subsection (7.1) or at any time after the application for a review is made if, in the opinion of a local director, there would be a risk that the child is likely to suffer harm during the time necessary for a review by the board.”

A child's safety must always be a priority guiding what CASs do and the actions of the organization. Any complaint review procedure cannot compromise the ability of a society to act to protect a child when necessary.

The Chair: Any debate?

Ms. Horwath: I just have a question. What happens where there is no local director? There is no language here that includes the situations we've heard about where, in some First Nations communities, there aren't the same types of resources. Could I just get an understanding, maybe from staff, what happens when there is no local director?

Ms. Gallagher: “Local director” refers to the executive director of a children's aid society. So in every case here there would be a local director.

Ms. Horwath: In every case there would be a local director?

Ms. Gallagher: These are children who would be placed in foster care, and there would be a children's aid society involved.

The Chair: Any further questions or debate? If there are none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 19, as amended, carry? Those in favour? Those opposed? Section 19 carries.

Shall section 20 carry? Those in favour? Those opposed? It carries.

Section 21, page 40: Mrs. Jeffrey.

Mrs. Jeffrey: I move that section 63.1 of the Child and Family Services Act, as set out in section 21 of the bill, be struck out and the following substituted:

“Society's obligation to a crown ward

“63.1 Where a child is made a crown ward, the society shall make all reasonable efforts to assist the child to develop a positive, secure and enduring relationship within a family through one of the following:

“1. An adoption.

“2. A custody order under subsection 65.2(1).

“3. In the case of a child who is an Indian or native person, a plan for customary care as defined in part X.”

The rationale for this is that we heard from the Chiefs of Ontario and the native organizations that adoption is generally considered by First Nations not to be culturally appropriate as an option for aboriginal children. A permanent customary care arrangement can enable a child to remain in their native community and be raised in a manner that preserves cultural identity and relationships. That's why this motion is here.

Ms. Horwath: You'll see that the next amendment, page 41, is one that addresses a similar issue. The way we've worded our amendment, though, is reflective of First Nations' preference that where a child has been made a crown ward, you go through a process that shows what their desires are first. What we've done—as you can see on page 41—is a ranking of the preferences that reflect the First Nations' preference in terms of, first, having the arrangement by the child's band or native community; second, a custody order; and last, adoption.

I'm going to be in a situation where this second motion that I have on the same section is going to be out of order, but when the time comes, I'm going to ask to read it into the record so that it's there.

The Chair: That's fair. Any debate? If there is none, I shall put the question. Those in favour? Those opposed? It carries.

You have the floor again, Ms. Horwath.

Ms. Horwath: I move that section 63.1 of the Child and Family Services Act, as set out in section 21 of the bill, be amended by adding the following subsection:

“Where child an Indian or native person

“(2) If the child who is made a crown ward is an Indian or native child, the society shall, in making efforts to assist the child to develop a positive, secure and enduring relationship within a family, give preference,

“(a) first, to an arrangement by the child's band or native community to provide customary care within the meaning of part X;

“(b) second, to a custody order made under section 65.2; and

“(c) last, to an adoption order made under part VII.”

The Chair: Any comments? You already made them before. This motion does add something to the one that was just approved, so it is fair on the floor. Is there any debate? If there's none, then I'll put the question. Those in favour of the motion? Opposed? It does not carry.

Shall section 21, as amended, carry? Those in favour? Those opposed? It does carry.

Section 22: Ms. Horwath, page 42.

Ms. Horwath: I move that section 64 of the Child and Family Services Act, as set out in section 22 of the bill, be amended by adding the following subsections:

"Same

"(5.1) A notice referred to in subsection (5) shall be given by the society on the same day the application is made or received, as the case may be, and shall be in the form approved by the minister.

"Postponement of review

"(5.2) Where a society receives notice of a date for a review by a court under this section, the society shall,

"(a) contact every person entitled to notice under subsection (5) to determine if notice was received by that person; and

"(b) if notice was not received by one of the persons contacted, give the person notice and apply to the court for a postponement of the review date."

Again, Mr. Chair, if I may, we heard very clearly from First Nations communities that all too often notices sent by representatives chosen by a child's First Nation or the First Nations are not received or not received sufficiently in advance of the hearing because of the remote nature of some of these communities. So there wasn't enough time permitting for the participation that's provided for in the act to actually occur. What this does is simply put some language in that makes it very clear that it's not just a matter of ensuring notice is sent but that in fact notice is received, and if notice isn't received, appropriate actions can occur so that the process isn't continuing inadvertently without appropriate timelines for participation to happen for First Nations communities.

The Chair: Any debate?

Mrs. Jeffrey: The family law rules and the Child and Family Services Act already set out rules to notices of application under the act. The government has concerns that both motions 42 and 43 are so restrictive that they would not allow the courts to dispense with services requirements in cases where there's an urgency or when it is necessary for the protection of a child. There are already processes in place to request postponement of review dates when there hasn't been adequate notice, so we won't be supporting the motion.

The Chair: Any further debate? If there's none, I shall put the question. Shall the motion carry? Those in favour? Those against? It does not carry.

Shall section 22 carry? Those in favour? Those opposed? It carries.

Shall section 23 carry? Those in favour? Those opposed? Carried.

Section 24: Ms. Horwath, page 43.

Ms. Horwath: I move that section 65.1 of the Child and Family Services Act, as set out in section 24 of the bill, be amended by adding the following subsections:

"Same

"(6.1) A notice referred to in subsection (6) shall be given by the society on the same day the application is made or received, as the case may be, and shall be in the form approved by the minister.

"Postponement of review

"(6.2) Where a society receives notice of a date for a review by a court under this section, the society shall,

"(a) contact every person entitled to notice under subsection (6) to determine if notice was received by that person; and

"(b) if notice was not received by one of the persons contacted, give the person notice and apply to the court for a postponement of the review date."

Again, similar to the previous motion, this simply builds in requirements to ensure that the notices have in fact been received, so instead of procedures just moving along with an assumption that notice has been received, this requires that follow-up be done to ensure that the notice was received. It's a more proactive way of ensuring that participation occurs in the way it's supposed to.

1100

The Chair: Thank you. Any debate? Mrs. Jeffrey.

Mrs. Jeffrey: Same argument as on 42. We're concerned the amendment is very restrictive and wouldn't allow the court to act and dispense with service requirements if there was an urgency that was necessary to the protection of the child, so we won't be supporting the amendment.

The Chair: Any further debate? If there's none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: 44.

Ms. Horwath: I move that section 65.2 of the Child and Family Services Act, as set out in section 24 of the bill, be amended by adding the following subsection:

"Consideration of financial support

"(1.1) In making an order under subsection (1), the court shall consider the availability of sufficient financial support and services for the care of the child."

Again, this is, as I've mentioned in previous amendments, the attempt to try to build in financial supports for the child.

The Chair: Any debate?

Mrs. Jeffrey: The government feels this amendment is not required, as the court has a responsibility to look at any plan to determine if it is in the child's best interests. This includes the availability of supports and services. Funding policies are being developed so that agencies can provide appropriate supports to families assuming the supervision and care of a child. The proposed amendment could have unintended consequences that result in a reluctance to participate in a plan for a child because the court must scrutinize the finances of a proposed caregiver. We won't be supporting the motion.

The Chair: Any further debate? If none, I'll put the question. Shall the motion carry? Those in favour? Those opposed. It does not carry.

Ms. Horwath: 45.

Ms. Horwath: I move that clause 65.2(4)(c) of the Child and Family Services Act, as set out in section 24 of the bill, be amended by striking out "but shall not require the society to provide financial assistance or purchase any goods or services" at the end and substituting "and

may require the society to provide financial assistance or goods or services if it would be in the best interests of the child.”

This amendment would allow for financial supports and services for children placed under a supervision order, and it requires the society to make sure that that happens. It’s one of those financial requirements that, although we understand that the government is indicating that they’ll undertake these things through policy, we think should be enshrined in legislation.

The Chair: Any debate?

Mrs. Jeffrey: We believe this motion would permit the court to impose financial obligations on a CAS, and as I stated earlier, Bill 210 is one component of a larger welfare transformation initiative. Greater supports, including financial supports, are most appropriately addressed through policy, not legislation. We have said that we’d like to see more children placed with someone they know and trust, be it an uncle, an aunt or a grandparent, and in many cases supports would be needed to make the placement both viable and sustainable. We won’t be supporting this motion.

The Chair: Any further debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Page 46: Mrs. Jeffrey.

Mrs. Jeffrey: I move that section 65.2 of the Child and Family Services Act, as set out in section 24 of the bill, be amended by adding the following subsection:

“Rights and responsibilities

“(7) A person to whom custody of a child is granted by an order under this section has the rights and responsibilities of a parent in respect of the child and must exercise those rights and responsibilities in the best interests of the child.”

This amendment makes it clear that the child’s legal guardian is the person who obtained custody of the child, and in plain language, where a custody order is made under section 65.2, placing a child in the custody of any person, including a foster parent, that person will have the rights and responsibilities of a parent with respect to the child and must exercise those rights in the best interests of that child.

The Chair: Any debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Shall section 24, as amended, carry? Those in favour? Those opposed? Carried.

Shall section 25 carry? Those in favour? Those opposed? Carried.

Section 26: Ms. Horwath, page 47.

Ms. Horwath: I move that subsection 68(1) of the Child and Family Services Act, as set out in section 26 of the bill, be amended by striking out “a complaint by a person concerning services sought or received by the person from the society” and substituting “a complaint concerning services sought or received by a person from the society.”

Again, this is a First Nations recommendation that indicates a provision should provide for a third party to request a review on behalf of the person who sought or received a service from a society.

The Chair: Any debate?

Mrs. Jeffrey: The complaints process is intended to address specific complaints of those immediately affected by the services sought or received. Nothing prohibits complainants from having a support person or an advocate to assist them in making their complaint. The complaint process is not designed or meant to deal with systemic issues. Those who are complaining about systemic issues can contact the CAS board of directors and/or the ministry at any point to make a general complaint. We won’t be supporting this motion.

The Chair: Any debate? If there is none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: page 48.

Ms. Horwath: I move that subsection 68(2) of the Child and Family Services Act, as set out in section 26 of the bill, be amended by striking out “by the person” and substituting “by the person or by another person.”

The Chair: Any questions?

Mrs. Jeffrey: Our arguments are the same on this motion. We won’t be supporting it.

The Chair: Any more debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Page 49: Ms. Wynne, please.

Ms. Wynne: I move that section 68 of the Child and Family Services Act, as set out in section 26 of the bill, be struck out and the following substituted:

“Complaint to society

“68(1) A person may make a complaint to a society relating to a service sought or received by that person from the society in accordance with the regulations.

“Complaint review procedure

“(2) Where a society receives a complaint under subsection (1), it shall deal with the complaint in accordance with the complaint review procedure established by regulation, subject to clause 68.1(2).

“Available to public

“(3) A society shall make information relating to the complaint review procedure available to any person upon request.

“Society’s decision

“(4) Subject to subsection (5), the decision of a society made upon completion of the complaint review procedure is final.

“Application for review by board

“(5) If a complaint relates to one of the following matters, the complainant may apply to the board in accordance with the regulations for a review of the decision made by the society upon completion of the complaint review procedure:

“1. An alleged inaccuracy in the society’s files or records regarding the complainant.

“2. A matter described in subsection 68.1(4).

"3. Any other prescribed matter.

"Review by board

"(6) Upon receipt of an application under subsection (5), the board shall give the society notice of the application and conduct a review of the society's decision.

"Composition of board

"(7) The board shall be composed of members with the prescribed qualifications and prescribed experience.

"Hearing optional

"(8) The board may hold a hearing and, if a hearing is held, the board shall comply with the prescribed practices and procedures.

"Non-application

"(9) The Statutory Powers Procedure Act does not apply to a hearing under this section.

"Board decision

"(10) Upon completing its review of a decision by a society in relation to a complaint, the board may,

"(a) in the case of a review of a matter described in paragraph 1 of subsection (5), order that a notice of disagreement be added to the complainant's file;

"(b) in the case of a matter described in subsection 68.1(4), make any order described in subsection 68.1(7), as appropriate;

"(c) redirect the matter to the society for further review;

"(d) confirm the society's decision; or

"(e) make such other order as may be prescribed.

"Notice of disagreement

"(11) A notice of disagreement referred to in clause (10)(a) shall be in the prescribed form if the regulations so provide.

"No review if matter within purview of court

"(12) A society shall not conduct a review of a complaint under this section if the subject of the complaint,

"(a) is an issue that has been decided by the court or is before the court; or

"(b) is subject to another decision-making process under the act or the Labour Relations Act, 1995.

"Transitional

"(13) This section as it read immediately before the day this subsection came into force continues to apply in respect of complaints made to a society before that day and of any reviews requested of the director before that day.

"Complaint to board

"68.1(1) If a complaint in respect of a service sought or received from a society relates to a matter described in subsection (4), the person who sought or received the service may,

"(a) decide not to make the complaint to the society under section 68 and make the complaint directly to the board under this section; or

"(b) where the person first makes the complaint to the society under section 68, submit the complaint to the board before the society's complaint review procedure is completed.

"Notice to society

"(2) If a person submits a complaint to the board under clause (1)(b) after having brought the complaint to the society under section 68, the board shall give the society notice of that fact and the society may terminate or stay its review, as it considers appropriate.

"Complaint to board

"(3) A complaint to the board under this section shall be made in accordance with the regulations.

"Matters for board review

"(4) The following matters may be reviewed by the board under this section:

"1. Allegations that the society has refused to proceed with a complaint made by the complainant under subsection 68(1) as required under subsection 68(2).

"2. Allegations that the society has failed to respond to the complainant's complaint within the time frame required by regulation.

"3. Allegations that the society has failed to comply with the complaint review procedure or with any other procedural requirements under the act relating to the review of complaints.

"4. Allegations that the society has failed to comply with clause 2(2)(a).

"5. Allegations that the society has failed to provide the complainant with reasons for a decision that affects the complainant's interests.

"6. Such other matters as may be prescribed.

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"Review by board

"(5) Upon receipt of a complaint under this section, the board shall conduct a review of the matter.

"Application

"(6) Subsections 68(7), (8) and (9) apply with necessary modification to a review of a complaint made under this section.

"Board decision

"(7) After reviewing the complaint, the board may,

"(a) order the society to proceed with a complaint made by the complainant in accordance with the complaint review procedure established by regulation;

"(b) order the society to provide a response to the complainant within a period specified by the board;

"(c) order the society to comply with the complaint review procedure established by regulation or with any other requirements under the act;

"(d) order the society to provide written reasons for a decision to a complainant;

"(f) dismiss the complaint; or"—

Mrs. Jeffrey: You just missed "(e)."

Ms. Wynne: Oh, sorry.

Ms. Sibylle Filion: Just read it in as (e) and we'll make the change.

Ms. Wynne: There is no (e) on my sheet. Oh, I'm sorry. Okay, I'll just go back, then:

"(d) order the society to provide written reasons for a decision to a complainant;

"(e) dismiss the complaint; or

"(f) make such other order as may be prescribed.

"No review if matter within purview of court

“(8) The board shall not conduct a review of a complaint under this section if the subject of the complaint,

“(a) is an issue that has been decided by the court or is before the court; or

“(b) is subject to another decision-making process under the act or the Labour Relations Act, 1995.”

The Chair: Any comments?

Mrs. Jeffrey: I’m going to repeat some of the things I’ve said before, but this is a really important amendment. Decisions under the CFSRB would be timely, neutral and binding as part of a standard, province-wide complaints process that we will have based on best practices. The director’s reviews of client complaints were removed as part of the initial bill because they were inconsistent and they were lengthy. We heard a lot from the witnesses about how frustrated they were, and at the end, they’re non-binding. The Ombudsman was concerned that under Bill 210, he would lose his oversight role. With the removal of the director’s review, we have addressed this concern by proposing the use of the CFSRB, because as a government agency, the Ombudsman would have authority over the CFSRB.

The Chair: Mrs. Munro and then Ms. Horwath, please.

Mrs. Munro: As everyone understands, certainly section 68 was an issue. We heard from many deputants. Particularly important was the number of individuals who chose this opportunity to come forward and make clear to all of us the kind of frustration that they had with the current process. I had an amendment prepared for section 68, and I just want to make clear that it in essence served the same purpose as this one, so I withdrew it. But I think it’s really important that we provide the public with the kind of consistency that would come with giving this board the responsibility for the contents of Bill 210. I look forward to the fact that this will then provide that consistency and, frankly, the comfort to those people who have come forward and expressed their frustration and concerns with the current system. We will be supporting this amendment.

Ms. Horwath: I just want to take the opportunity to read into the record some concerns that the Ombudsman raised around this solution. He says: “It’s a stopgap measure which does not go far enough. All it does is add another layer of bureaucracy to internal processes.”

The Ombudsman pointed out that the Child and Family Services Review Board, which will operate under limited jurisdiction, lacks both investigative powers and the power to address systemic issues affecting children and families. “You are talking about protecting our children. How many more cases like Jeffrey Baldwin will there be before the government wakes up and sees we need stronger accountability, the kind that comes from having an independent watchdog with strong investigative powers?”

I do understand that the government has chosen to go this route as opposed to the one that I suggested through my amendment to let the Ombudsman have the oversight over the children’s aid societies. I only hope that five

years from now, when we look back, people are more satisfied with the process than they are now and that we end up in a situation where people do feel that there is accountability in the system, because they certainly don’t feel that now.

I do wish it had gone a different way, but I understand that since my motion wasn’t supported, the government obviously has to put something in place to address the concerns that have come forward. I only hope that the future will prove that the right thing was done. I’m not so sure that that’s the case.

Mr. Ted Arnott (Waterloo–Wellington): Mr Chair, the Ombudsman is an independent officer of the Legislature who reports to the Legislature as a whole, not to the government, and when the Ombudsman comes into the standing committee to make a presentation on a bill like Bill 210, I think it’s something we should all listen to very carefully. I understand he was here on December 6, and in his initial submission to this committee he asked that an amendment be brought forward—and I’ll quote from his report—saying that “Approved agencies designated as children’s aid societies under subsection 15(2) shall be deemed to be governmental organizations for the purposes of the Ombudsman Act.”

I would certainly like to say that, while I hear the parliamentary assistant and the government acknowledging that the Ombudsman has an issue, it is quite clear that the government is not prepared to respond to the Ombudsman in the way that he has requested. I want that to be clearly stated on the record.

The Chair: Any further debate?

Mrs. Jeffrey: On the issue of the Ombudsman, we share the Ombudsman’s concern for the best interests of children and the child protection systems we have. I think we all care about that issue; we just disagree how we’ll get there. But we clearly want to change the way the system works and we want to provide the best system possible. This is the solution we think will work best.

Mr. Arnott: It appears to me, if I’m not mistaken, it’s also, to use the government’s word, the solution that will limit the number of complaints that will go to the Ombudsman dramatically, as opposed to what the Ombudsman is requesting in terms of his ability to respond to complaints. Only a fraction of the complaints will come to the attention of the Ombudsman if you have to go through the appeal board first. Again, I’ll just put that on the record because I think it’s important that the committee be aware of what it’s voting on.

The Chair: Any further debate? If there’s none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 26, as amended, carry? Those in favour? Those opposed? It does carry.

Section 27: Ms. Horwath, page 50.

Ms. Horwath: I move that subsection 71(2) of the act, as set out in section 27 of the bill, be amended by adding at the end “until the crown ward or former crown ward attains the age of 25 years, whether or not he or she has been adopted.”

What this does is allow for extended care and maintenance to be available until the age of 25 for children who age out of foster care. I think anyone who was attending the hearings will recall that young people were concerned that, as a result of some of the challenges that have led them to be in foster care or in the child protection system, it takes them a little bit longer to pull themselves into a position where they can start taking advantage of things, for example, post-secondary education and other opportunities.

This is a way of acknowledging that there are challenges for young people, and the more we are able to provide for their extended care and maintenance to a greater age so that they can take the time to make decisions and to undertake initiatives towards, for example, post-secondary education or other kinds of opportunities that might be available to them, we should do so. This is a way of extending the age to 25 in acknowledgement that young people, we know, even in families where there are no child protection issues, are taking longer to leave the nest, you would say. So it's appropriate, then, to acknowledge that trend in this legislation as well by providing that extended care and maintenance till beyond the age of 18; in fact, beyond the age of 21 to the age of 25.

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The Chair: Any debate?

Mrs. Jeffrey: We recognize that achieving a strong permanent plan for a child will require the availability of post-adoption supports. We're committed to the provision of a funding policy that will enable the provision of appropriate post-adoption supports by children's aid societies. The intention of continuing care and maintenance is to provide supports for young people where the permanency of legal adoption has not been available.

The government's motion 53 will expand extended care and maintenance so it is available for youth at age 18 or former crown wards who were cared for under a customary care agreement or a custody order if they meet the eligibility criteria. So we won't be supporting this motion.

The Chair: Any further debate? If there's none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: page 51, please.

Ms. Horwath: I move that section 27 of the Bill be amended by adding the following subsection:

"(2) Section 71 of the act is amended by adding the following subsection:

"Care and maintenance for Indian or native child in customary care

"(3) If a band or native community has declared that an Indian or native child is being cared for under customary care, the society may continue to provide care and maintenance in accordance with the regulations until the Indian or native child attains the age of 25 years, whether or not he or she has been adopted."

Again, this is similar language. It was raised by First Nations, and their rationale is that it is agreed that any

relatives and foster parents who become legal guardians for youth may have limited financial means and youth could potentially be faced with no financial supports if they're preparing for independence and/or attending post-secondary education. It is therefore proposed that this clause be strengthened to require that societies make a transitional plan in consultation with those involved and to provide care and maintenance as agreed to under the plan. Then the next amendment will deal with transitional plans.

The Chair: Any debate?

Mrs. Jeffrey: Same argument as the previous motion. The government's motion coming up, number 53, will expand extended care and maintenance so it's available to youth at age 18 or former crown wards. So we won't be supporting this motion.

The Chair: Any debate? If there's none, I'll take the vote. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: page 52.

Ms. Horwath: I move that subsection 71(2) of the Child and Family Services Act, as set out in section 27 of the bill, be struck out and the following substituted:

"Continuing care

"(2) Where a custody order under subsection 65.2(1) or an order for crown wardship expires under subsection (1) or is otherwise terminated and continued care and maintenance for the person who was the subject of the order is required to ensure a successful transition, the society shall,

"(a) continue to provide care and maintenance in accordance with the regulations after the order expires or is terminated under a transitional plan prepared in accordance with subsection (3); and

"(b) if the person who was the subject of the order is an Indian or native person, give at least three months' notice of the expiry or termination to a representative chosen by the child's band or native community.

"Transition plan

"(3) A transition plan referred to in clause (2)(a) shall be prepared by the society in consultation with the child who was the subject of the expired or terminated order, the person who will be providing the continued care and maintenance and, if the child is an Indian or native person, a representative chosen by the child's band or native community."

Again, this just outlines the transitional plan requirement.

The Chair: Is there any debate?

Mrs. Jeffrey: Extended care and maintenance occurs when the children's aid society and the youth are able to reach an agreement related to a planned transition to independence, including education, training and employment. We believe the government motion provides flexibility in the act to provide extended care and maintenance for former crown wards or children who were cared for under a customary care arrangement or a custody order where they meet the eligibility criteria. Further policy development is underway, with the intent of improving

the services provided by children's aid societies regarding supports for youth preparing for independence. We won't be supporting this motion.

The Chair: Any further debate? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Page 53: Mrs. Jeffrey.

Mrs. Jeffrey: I move that section 27 of the bill be struck out and the following substituted:

"27. Subsection 71(2) of the act is repealed.

"27.1 The act is amended by adding the following section:

"EXTENDED CARE

"Extended care

"71.1(1) A society may provide care and maintenance to a person in accordance with the regulations if,

"(a) a custody order under subsection 65.2(1) or an order for crown wardship was made in relation to that person as a child; and

"(b) the order expires under section 71.

"Same, Indian and native person

"(2) A society or agency may provide care and maintenance in accordance with the regulations to a person who is an Indian or native person who is 18 years of age or more if,

"(a) immediately before the person's 18th birthday, he or she was being cared for under customary care as defined in section 208; and

"(b) the person who was caring for the child was receiving a subsidy from the society or agency under section 212."

The rationale is that for aboriginal children and youth, customary care is a culturally appropriate form of permanent care. This amendment would permit the same transitional supports that otherwise would be available if the youth remained in care as a crown ward. This amendment will promote cultural continuity in the case of youth and, as well, it will help education and economic security of our aboriginal youth.

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? The motion carries.

Shall section 27, as amended, carry? Those in favour? Those opposed? It carries.

Shall section 28 carry? Those in favour? Those opposed? It carries.

Section 29: Mr. Leal, please.

Mr. Leal: I move that section 29 of the bill be struck out and the following substituted:

"29.(1) Subsection 80(1) of the act is repealed and the following substituted:

"Restraining order

"(1) Instead of making an order under subsection 57(1) or section 65.2 or in addition to making a temporary order under subsection 51(2) or an order under subsection 57(1) or section 65.2, the court may make one or more of the following orders in the child's best interests:

"1. An order restraining or prohibiting a person's access to or contact with the child, and may include in the order such directions as the court considers appropriate for implementing the order and protecting the child.

"2. An order restraining or prohibiting a person's contact with the person who has lawful custody of the child following a temporary order under subsection 51(2) or an order under subsection 57(1) or clause 65.2(1)(a) or (b).

"(2) Subsection 80(3) of the act is repealed and the following substituted:

"Duration of the order

"(3) An order made under subsection (1) shall continue in force for such period as the court considers in the best interests of the child and,

"(a) if the order is made in addition to a temporary order under subsection 51(2) or an order made under subsection 57(1) or clause 65.2(1)(a), (b) or (c), the order may provide that it continues in force, unless it is varied, extended or terminated by the court, as long as the temporary order under subsection 51(2) or the order under subsection 57(1) or clause 65.2(1)(a), (b) or (c), as the case may be, remains in force; or

"(b) if the order is made instead of an order under subsection 57(1) or clause 65.2(1)(a), (b) or (c) or if the order is made in addition to an order under clause 65.2(1)(d), the order may provide that it continues in force until it is varied or terminated by the court.

"(3) Clause 80(5)(a) of the act is repealed and the following substituted:

"(a) extend the order for such period as the court considers to be in the best interests of the child, in the case of an order described in clause (3)(a); or."

Mrs. Jeffrey: This is a housekeeping amendment. The amendment will permit a court to make restraining orders at any time in a protection case, and for a period of time necessary to protect the child and the caregiver.

The Chair: Is there any comment or debate? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Shall section 29, as amended, carry? Those in favour? Those opposed? It carries.

Shall section 30 carry? Those in favour? Those opposed? It carries.

Section 30.1 is a new section. Ms. Horwath, pages 55 and 55a, please.

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Ms. Horwath: I move that the bill be amended by adding the following section:

"30.1 The act is amended by adding the following sections:

"Child advocate

"102.1(1) Within 30 days after this section comes into force, or so soon after as possible, the Lieutenant Governor in Council shall, on the address of the Legislative Assembly, appoint a person to be the Children Advocate to be responsible for the operation of the Office of Child and Family Service Advocacy.

““Officer of the assembly

“(2) The Child Advocate is an officer of the assembly.

““Term of office

“(3) Subject to subsection (4), the Child Advocate shall hold office for a term of five years, and may be re-appointed for further terms of five years each.

““Removal from office

“(4) The Lieutenant Governor in Council may at any time remove the Child Advocate from office for cause, on the address of the Legislative Assembly.

““Report to the Legislative Assembly

“102.2(1) The Child Advocate shall, in every year, make a report in writing and shall deliver the report to the Speaker of the Legislative Assembly.

““Contents

“(2) The report mentioned in subsection (1) shall contain whatever information the Child Advocate considers appropriate, but shall contain, at a minimum, a report on the activities and finances of the Office of Child and Family Service Advocacy, the outcomes expected in the next year, and the results achieved in the previous year.

““Laying before assembly

“(3) The Speaker shall lay the report before the assembly at the earliest reasonable opportunity.”

I think it's obvious that this amendment addresses the Liberal promise to make the Child Advocate an independent officer of the Legislature. That promise, of course, was made quite some time ago and still hasn't been realized. I felt it was appropriate to bring this amendment in the context of this bill because it's time that promise be acted upon. This is a very easy way to have that promise acted upon because now we can just accept this amendment and it will be done.

The Chair: Any comments?

Mrs. Jeffrey: We did make a promise that we would have a child advocate, and we haven't done it yet. We're going to be bringing forward legislation to do that, and this is a good place to talk about it. The government is committed to establishing a truly independent advocate for children and youth to strengthen their voices. Government legislation on the advocate will be separate from the CFSA. If the government legislation is passed, it will create an independent child advocate. We'll be using the NDP motion as guidance, and we appreciate the interest and work that's gone into the motion. We'll try to create a bill that will contain the necessary components to create an independent officer of the Legislature.

The Chair: Any further debate? If there is none, I'll take the vote. Shall the motion carry? Those in favour? Those opposed? It does not carry. So there is no section to vote on.

Shall section 31 carry? Those in favour? Those opposed? It carries.

Section 32: Mrs. Jeffrey, please, page 56.

Mrs. Jeffrey: I move that the definition of “openness order” in subsection 136(1) of the Child and Family Services Act, as set out in subsection 32(2) of the bill, be amended by striking out “or” at the end of clause (a), by

adding “or” at the end of clause (b) and by adding the following clause:

“(c) if the child is an Indian or native person, a member of the child's band or native community who may not have had a significant relationship or emotional tie with the child in the past but will help the child recognize the importance of his or her Indian or native culture and preserve his or her heritage traditions and cultural identity.”

We clearly heard from the Chiefs of Ontario and the native organizations that permitting a member of an aboriginal child's band or native community to be the subject of an openness order broadens and better promotes the likelihood that a child will maintain a cultural tie after adoption. This motion hopes to achieve that.

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? The motion carries.

Shall section 32, as amended, carry? Those in favour? Those opposed? It carries.

Section 33: Ms. Horwath, page 57.

Ms. Horwath: I move that section 33 of the bill be amended by adding the following subsection:

“(3) Subsection 140(3) of the act is repealed and the following substituted:

“Where child an Indian or native person

“(3) Where a child to be placed for adoption is an Indian or a native person, the society shall notify the child's band or native community and shall consult with a representative chosen by the child's band or native community on the selection of an adoption placement.”

This is something that was recommended by First Nations communities, and it makes it clear that the society will consult, given the principle of openness, with First Nations on the selection of an appropriate permanent placement.

Mrs. Jeffrey: We feel that government motion 70 will better address consultation in a broader fashion. It will allow regulations to be made requiring consultation in individual cases, including consultation on adoption placements. Government motion 59 strengthens the involvement of a native child's band or their community in the adoption planning process. It requires early notice in the process, prohibits the child placement before the band has an opportunity to respond and provides specific and extended time frames for band participation, so we won't be supporting this motion.

The Chair: Any debate? If there's none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: 58.

Ms. Horwath: I move that section 33 of the bill be amended by adding the following subsections:

“Care and maintenance after adoption

“(4) The society may continue to provide care and maintenance for a child in accordance with the regulations after the child is adopted until the child or former child attains the age of 25 years.

“Financial assistance

“(5) A person with whom a child is placed for adoption may apply to the society in accordance with the regulations for financial assistance for the care of the child.

“Regulations

“(6) The Lieutenant Governor in Council may make regulations governing the application for and the payment by a society of financial assistance to persons with whom a child is placed for adoption.”

This is an amendment that would allow for extended care and maintenance to be available to children up until the age of 25 and for financial supports and services to be made available to children and guardians and adoptive parents. Again, it's a way of trying to enshrine this in legislation. We know that circumstances can always change, and if financial assistance up to the age of 25 is what will help to ensure that the placement remains stable and successful, or an adoption remains a successful placement for a child, then that's what we should be doing.

The Chair: Any debate?

Mrs. Jeffrey: In previous motions, we've supported extending care and maintenance to age 18, and this motion extends it to 25. As well, with regard to the financial component of this motion, we've already indicated that we are going to recognize that financial assistance is imperative to having a successful outcome and making a placement viable and stable, so we won't be supporting this motion.

The Chair: Any further debate? If there's none, I'll put the question. Shall the motion carry? All those in favour? Those opposed? Does not carry.

Is it Mr. Fonseca or Mr. Leal for 59(a)?

Mr. Craitor: I move that section 33 of the bill be struck out and the following substituted:

“33. Section 140 of the act is repealed.

“33.1 The act is amended by adding the following sections:

““Limitation on placement by society

“141.1 A society shall not place a child for adoption until,

“(a) any outstanding order of access to the child made under subsection 58(1) of part III has been terminated; and

“(b) if the child is a crown ward,

“(i) the time for commencing an appeal of the order for crown wardship under subsection 57(1) or 65.2(1) has expired, or

“(ii) any appeal of the order for crown wardship has been fully disposed of or abandoned.

“Where child an Indian or native person

“141.2(1) If a society intends to begin planning for the adoption of a child who is an Indian or native person, the society shall give written notice of its intention to a representative chosen by the child's band or native community.

“Care plan proposed by band or native community

“(2) Where a representative chosen by a band or native community receives notice that a society intends

to begin planning for the adoption of a child who is an Indian or native person, the band or native community may, within 60 days of receiving the notice,

“(a) prepare its own plan for the care of the child; and

“(b) submit its plan to the society.

“Condition for placement

“(3) A society shall not place a child who is an Indian or native person with another person for adoption until,

“(a) at least 60 days after notice is given to a representative chosen by the band or native community have elapsed; or

“(b) if a band or native community has submitted a plan for the care of the child, the society has considered the plan.”

1140

The Chair: Any comments?

Mrs. Jeffrey: The government motion on this matter strengthens and enhances the requirements for band involvement in adoption planning. In the motion, the band or the native community has 60 days after receiving notice to put forward a plan. The society cannot place a child for adoption until those 60 days have expired or the society has considered any plan that has been put forward by the band and native community. It requires early notice in the process, prohibits the child's placement before the band has an opportunity to respond, and provides specific and extended time frames for band participation.

The Chair: Any debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 33, as amended, carry? Those in favour? Against? It does carry.

Section 34: Ms. Horwath, page 60.

Ms. Horwath: I move that subsection 144(2) of the Child and Family Services Act, as set out in section 34 of the bill, be amended by striking out “and” at the end of clause (a) and adding the following clause:

“(a.1) if the child is an Indian or native person,

“(i) shall give notice to a representative chosen by the child's band or native community of a decision not to place the child with the person who had applied to adopt the child or of a decision to remove the child from the person with whom he or she had been placed for adoption, and

“(ii) shall consult with the representative on the selection of an alternative adoption placement; and.”

The Chair: Any debate on the motion?

Mrs. Jeffrey: We believe that government motion 62 is more comprehensive than motions 60 and 61 put forward by the NDP. Motion 62 includes the notice and consultation requirements and also gives the child's band and native community party status where a hearing is held. The government's motion provides for a neutral, independent review by the Child and Family Services Review Board. So we won't be supporting this motion.

The Chair: Any further debate? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Mr. Fonseca: 62, please. Sorry, we still have 61. My apologies. I go back to Ms. Horwath.

Ms. Horwath: Since the issue is covered off in the government's next motion, I'll withdraw this one.

The Chair: It has been withdrawn.

Mr. Fonseca, back to you.

Mr. Peter Fonseca (Mississauga East): I move that section 144 of the Child and Family Services Act, as set out in section 34 of the bill, be struck out and the following substituted:

"Decision of society or licensee

"144(1) This section applies if,

"(a) a society decides to refuse an application to adopt a particular child made by a foster parent, or other person; or

"(b) a society or licensee decides to remove a child who has been placed with a person for adoption.

"Notice of decision

"(2) The society or licensee who makes a decision referred to in subsection (1) shall,

"(a) give at least 10 days' notice in writing of the decision to the person who applied to adopt the child or with whom the child had been placed for adoption;

"(b) include in the notice under clause (a) notice of the person's right to apply for a review of the decision under subsection (3); and

"(c) if the child is an Indian or native person,

"(i) give at least 10 days' notice in writing of the decision to a representative chosen by the child's band or native community, and

"(ii) after the notice is given, consult with the band or community representatives relating to the planning for the care of the child.

"Application for review

"(3) A person who receives notice of a decision under subsection (2) may, within 10 days after receiving the notice, apply to the board in accordance with the regulations for a review of the decision subject to subsection (4).

"Where no review

"(4) If a society receives an application to adopt a child and, at the time of the application, the child had been placed for adoption with another person, the applicant is not entitled to a review of the society's decision to refuse the application.

"Board hearing

"(5) Upon receipt of an application under subsection (3) for a review of a decision, the board shall hold a hearing under this section.

"Where child is Indian or native person

"(6) Upon receipt of an application for review of a decision relating to a child who is an Indian or native person, the board shall give a representative chosen by the child's band or native community notice of the application and of the date of the hearing.

"Practices and procedures

"(7) The Statutory Powers Procedure Act applies to a hearing under this section and the board shall comply with such additional practices and procedures as may be prescribed.

"Composition of board

"(8) At a hearing under subsection (5), the board shall be composed of members with the prescribed qualifications and prescribed experience.

"Parties

"(9) The following persons are parties to a hearing under this section:

"1. The applicant.

"2. The society.

"3. If the child is an Indian or a native person, a representative chosen by the child's band or native community.

"4. Any person that the board adds under subsection (10).

"Additional parties

"(10) The board may add a person as a party to a review if, in the board's opinion, it is necessary to do so in order to decide all the issues in the review.

"Board decision

"(11) The board shall, in accordance with its determination of which action is in the best interests of the child, confirm or rescind the decision under review and shall give written reasons for its decision.

"Subsequent placement

"(12) After a society or licensee has made a decision referred to in subsection (1) in relation to a child, the society shall not place the child for adoption with a person other than the person who has a right to apply for a review under subsection (3) unless,

"(a) the time for applying for a review of the decision under subsection (3) has expired and an application is not made; or

"(b) if an application for a review of the decision is made under subsection (3), the board has confirmed the decision.

"No removal before board decision

"(13) Subject to subsection (14), if a society or licensee has decided to remove a child from the care of a person with whom the child was placed for adoption, the society or licensee, as the case may be, shall not carry out the proposed removal of the child unless,

"(a) the time for applying for a review of the decision under subsection (3) has expired and an application is not made; or

"(b) if an application for a review of the decision is made under subsection (3), the board has confirmed the decision.

"Where child at risk

"(14) A society or licensee may carry out a decision to remove a child from the care of a person with whom the child was placed for adoption before the expiry of the time for applying for a review under subsection (3) or at any time after the application for a review is made if, in the opinion of a director or local director, there would be a risk that the child is likely to suffer harm during the time necessary for a review by the board.

"Transitional

"(15) This section as it read immediately before the day this subsection came into force continues to apply

where a request to adopt a child or a decision to remove a child was made before that day.”

The Chair: Any comments?

Mrs. Jeffrey: We believe that, in appropriate cases, a review of a society’s decision should occur before a neutral third party. That’s why we’ve introduced the Child and Family Services Review Board. As I said earlier, those reviews will be timely, neutral and binding. Through the notice and participation, the board can promote consideration and preservation of a child’s cultural and community connections. That’s what this will do.

The Chair: Any debate on the motion? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? The motion does carry.

Shall section 34, as amended, carry? Those in favour? Those opposed? Carried.

Shall section 35 carry? Those in favour? Those opposed? It does carry.

Section 36: Ms. Horwath, page 63.

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Ms. Horwath: I move that subsection 145.1(1) of the Child and Family Services Act, as set out in section 36 of the bill, be struck out and the following substituted:

“Application to make openness order

“145.1(1) If a child who is a crown ward is the subject of a plan for adoption, and no access order is in effect under part III, the society having care and custody of the child or a birth parent of the child may apply to the court for an openness order in respect of the child at any time before an order for adoption of the child is made under section 146.”

People will note that the amendment here deals with the birth parents having a right to apply for openness orders, and that’s about it.

The Chair: Any comments?

Mrs. Jeffrey: The motion is not supportable, as Bill 210 will only permit the society to apply for an openness order, and the order can’t be made unless all parties consent. Expanding the persons who may apply for an order could destabilize the critical period before adoption finalization if frivolous applications are brought forward. The possibility of a birth family initiating an application could have the unintended consequence of discouraging prospective adoptive parents agreeing to openness arrangements. So we won’t be supporting the motion.

The Chair: Is there any debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Ms. Horwath: page 64.

Ms. Horwath: I move that subsection 145.1(2) of the Child and Family Services Act, as set out in section 36 of the bill, be amended by striking out the portion before clause (a) and substituting the following:

“Notice of application

“(2) A society or birth parent making an application under this section shall give notice of the application to.”

Again, it’s just a matter of recognizing the participation of birth parents.

The Chair: Any questions or debate on the motion?

Mrs. Jeffrey: We reject this motion for the same reasons as previously.

The Chair: Any further debate? If there’s none, I’ll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Is it Mr. Leal? Ms. Jeffrey: page 65.

Mrs. Jeffrey: I move that clause 145.1(3)(c) of the Child and Family Services Act, as set out in section 36 of the bill, be struck out and the following substituted:

“(c) the following entities and persons have consented to the order:

“(i) the society,

“(ii) the person who will be permitted to communicate with or have a relationship with the child if the order is made,

“(iii) the person with whom the society has placed or plans to place the child for adoption, and

“(iv) the child if he or she is 12 years of age or older.”

The Chair: Any comments?

Mrs. Jeffrey: Essentially the rationale is, it’s vitally important to acknowledge the voices of youth in major decisions affecting their lives. I think we heard that quite eloquently from the young people we had here. Youth may have specific recommendations on how to improve the adoption openness arrangement that will be included in the order. At the hearings we watched some very moving presentations, and we’ve taken that to heart.

The Chair: Any debate on the motion? If there’s none, I’ll put the question. Shall the motion carry? In favour? Against? It carries.

Ms. Munro: page 66.

Mrs. Munro: I move that section 36 of the bill be amended by adding the following section:

“Review of effectiveness of openness orders and openness agreements

“145.3(1) Within three years after section 145.1 comes into force or section 153.6 comes into force, whichever is later, the Lieutenant Governor in Council shall, after consultation with the minister, appoint a person who shall undertake a comprehensive review of the effectiveness of openness orders and openness agreements in assisting societies in increasing the number of adoptions of crown wards in Ontario and report on his or her findings to the minister.

“Contents of report

“(2) Without limiting the generality of subsection (1), a report shall include recommendations for improving the effectiveness of this act and the regulations with respect to openness arrangements and adoptions of crown wards.

“Tabling of report

“(3) The minister shall submit the report to the Lieutenant Governor in Council and shall cause the report to be laid before the assembly if it is in session or, if not, at the next session.”

The Chair: Any comments?

Mrs. Munro: I would like the committee to give consideration of this amendment. I think all of us recognized the intent of the bill was, as the minister herself was very clear, about increasing the number of adoptions in this

province. As we know, a great deal of this bill, and, I think, with some justification, means that a lot will be covered in regulation; and obviously regulation, while an important part of the legislative process, falls outside of the legislation. It seems to me that there's an opportunity, then, or should be an opportunity, I would argue—that it is important to be able to have a review. There are many parts of this bill, frankly, that are in uncharted waters for the province. It certainly represents some bold initiatives that are being undertaken.

I think it's a recognition as well that children's aid societies, as the major proponent, if you like, in terms of the carrying out of this legislation, have a great deal to do. There has been recognition in the submissions made, from all of the children's aids across the province, of the importance of providing consistency, as well as the importance the role of new technology will play and the importance of training the people who are involved in carrying out this bill.

The issue around alternative dispute resolution has certainly been one that I think has received very large support amongst those who have made submissions to this committee. But again, the methodologies and the actual way in which that will work out are left to regulation, and they are left to the process in terms of when it is going to be most effective and the kinds of issues around determining best practices.

During the public hearings, we heard much about the aboriginal concerns that have been raised. Certainly, by the kinds of amendments we've heard here this morning, there has been an attempt to address those concerns.

There's clearly going to be a significant cost associated with the implementation of this bill.

The fact that there are so many areas where a very good intention is embedded in this piece of legislation—it would seem to me that all members of the House would want to be assured by a review of the nature that I'm proposing, that in fact the legislation is meeting those goals. I would suggest to you that in looking at the amendment I've proposed with regard to the contents of the report, I've specifically suggested here that it include recommendations for improving the effectiveness of the act. Obviously, when you're looking at the kind of direction that is embedded in this bill and all of the things that will have to necessarily fall in regulation—best practices, training and things like that—it seems to me that it behooves us as legislators to recognize there may be issues that arise that quite frankly need to be addressed. This amendment would allow for that kind of report to be made and for recommendations then to go to the minister. Obviously, having it laid before the assembly would mean that it would allow all members of the House to understand and appreciate both the progress and the possible issues around effectiveness, not only of the legislation and the ministry but also its providers through the CAS, through the aboriginal community, through all of the people who have a role to play, and, quite frankly, to never forget our actual goal, which is of course to serve the children of this province in a better way.

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I would just sum up and suggest that providing this kind of avenue really puts all of us as legislators on notice that we recognize how important it is to be able to provide the most effective method of ensuring the safety and a brighter future for those children who need that attention.

The Chair: Mr. Arnott, do you wish to add something at this point?

Mr. Arnott: Mrs. Munro has provided the committee with a very eloquent and thoughtful presentation as to why this amendment to section 36 ought to be passed by the government. I would certainly concur and agree that there needs to be a review of the effectiveness of openness orders and openness agreements after a three-year period so as to ensure that this legislation, the children's aid societies, the ministry and everything that we're trying to do to protect children is in fact happening, and to ensure that if there are any further changes needed after that point in time, they can be made. I think it's also important that the review and report not just go to the minister but that it also be public, and if it's tabled in the Legislature, of course, it becomes a public document. So I would encourage and urge the government members to support this amendment.

The Chair: Mrs. Jeffrey.

Mrs. Jeffrey: The ministry will be reviewing the effectiveness of the child welfare transformation, including Bill 210 provisions related to openness, on an ongoing basis. We believe the motion is not required. Bill 210 is only one aspect of the transformation. Therefore, we won't be supporting the motion.

The Chair: Is there any further debate? If there is none, I'll put the question. Shall the motion carry? Those in favour?

Mr. Arnott: Recorded vote.

Ayes

Arnott, Horwath, Munro.

Nays

Fonseca, Jeffrey, Leal, Wynne.

The Chair: The motion does not carry.

Shall section 36, as amended, carry? Those in favour? Those opposed? It does carry.

Shall section 37 carry? Those in favour? Those opposed? It carries.

Section 38: Mrs. Jeffrey, page 67.

Mrs. Jeffrey: I move that subsection 153.6(1) of the Child and Family Services Act, as set out in section 38 of the bill, be amended by adding the following paragraph:

"5. If the child is an Indian or native person, a member of the child's band or native community who may not have had a significant relationship or emotional tie with the child in the past but will help the child recognize the importance of his or her Indian or native culture and

preserve his or her heritage traditions and cultural identity.”

This amendment reinforces the importance of maintaining cultural ties for aboriginal children. The section is broadened for aboriginal children to include a member of the child's band or native community who does not have a relationship with the child at the time the openness agreement's made, but will help the child maintain their ties. It will permit a member of the child's band or native community to be a party to an openness agreement and broadens and better promotes the likelihood that a child will maintain their cultural ties within his or her community.

The Chair: Is there any debate on the motion? If there's none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? The motion does carry.

Page 68, please.

Mrs. Jeffrey: I move that subsection 153.6(2) of the Child and Family Services Act, as set out in section 38 of the bill, be struck out and the following substituted:

“When agreement may be made

“(2) An openness agreement may be made at any time before or after an adoption order is made.”

This motion permits flexibility in the timing of openness agreements, recognizing that these matters are consensual and may take time to work through. It also removes the requirement for consents to be signed before entering into an openness agreement, and it's consistent with current practices in private adoptions.

The Chair: Any debate? If there's none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? The motion does carry.

Shall section 38, as amended, carry? Those in favour? Those opposed? It does carry.

Shall section 39 carry? Those in favour? Those opposed? It carries.

Section 39.1: Ms. Horwath, page 69.

Ms. Horwath: I move that the bill be amended by adding the following section:

“39.1 Subsection 158(2) of the act is amended by striking out ‘as if the adopted child had been born to the adopted parent’ after clause (b).”

This is just to reflect the concern that was raised that the language is in fact outdated and punitive language.

The Chair: Ms. Horwath, I have to declare your motion out of order because that section was not open on the bill. Therefore, there is no debate and there is no motion. The motion is out of order.

Mrs. Jeffrey: Mr. Chair, could I make a suggestion? In fact, it's out of the scope of the bill, but should it receive unanimous consent, then it could go forward.

The Chair: Okay. Are you requesting unanimous support?

Ms. Horwath: I'm sorry?

The Chair: Are you asking that—

Ms. Horwath: Oh, okay. So instead of putting it as a motion, I'll ask for unanimous consent that this motion be considered by committee?

The Chair: Yes, and if that carries—do I have unanimous consent on this? I do. Okay. Now you can put the motion.

Ms. Horwath: Thank you very much, then.

I move that the bill be amended by adding the following section:

“39.1 Subsection 158(2) of the act is amended by striking out ‘as if the adopted child had been born to the adopted parent’ after clause (b).”

The Chair: Is there any debate?

Mrs. Jeffrey: The government recognizes that these words have a very significant emotional impact for a child and the legal consequences of removing the words are minimal. Therefore, we support the motion.

The Chair: Any further debate? If not, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Section 39.1, new, page 70.

Mrs. Jeffrey: I move that the bill be amended by adding the following section:

“39.1 The act is amended by adding the following section:

““Consultation in specified cases

“213.1 A society or agency that proposes to provide a prescribed service to a child who is an Indian or native person or to exercise a prescribed power under the act in relation to such a child shall consult with a representative chosen by the child's band or native community in accordance with the regulations.””

The aboriginal leaders have identified inconsistency in both the frequency and the quality of the consultations with societies. This new section would require children's aid societies to consult with an aboriginal child's band or native community in cases where the society is exercising a power or providing a service to the child and his family. Clear expectations regarding consultation will enhance the mutual information-sharing and focus societies on their ongoing obligations to native children and their families.

The Chair: Any debate? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Section 39.2: pages 71 and 71a.

Ms. Horwath: I move that the bill be amended by adding the following section:

“39.2 Part X of the act is amended by adding the following sections:

““Reports by society

“213.1(1) A society or agency that provides services or exercises powers under this act with respect to children who are members of or entitled to membership in a band or native community shall provide quarterly reports on the status of those children to the band or native community.

“Content of report

“(2) A report prepared under subsection (1) shall,

“(a) list the names of the Indian or native children;

“(b) specify the service status of each child; and

“(c) provide dates and locations of any upcoming events for which the representative of the band or native community is required to be provided with notice under the act.

“Report by director

“213.2 The director shall monitor compliance by societies with their obligations under this act to Indian and native persons and to bands and native communities and shall prepare an annual report and make it available to the public in accordance with the regulations.”

The Chair: Any comments?

Mrs. Jeffrey: The government believes this motion is unnecessary, as enhanced notification and consultation requirements should improve band and native community participation. The ministry will be reviewing the effectiveness of the child welfare transformation on an ongoing basis, including Bill 210 provisions. We won't be supporting the motion.

The Chair: Further debate?

Ms. Horwath: Again, not dissimilar to other motions I've put forward this morning. The point is that by enshrining some of this language in legislation, there's a greater sense that the consultation and respect for aboriginal provisions will be more greatly enforced.

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The Chair: Any further debate? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those opposed? It does not carry.

Shall section 40 carry? Those in favour? Those opposed? It carries.

Section 41: page 72.

Ms. Wynne: I move that clauses 216(b.2), (b.3) and (b.4) of the Child and Family Services Act, as set out in section 41 of the bill, be struck out and the following substituted:

“(b.2) respecting applications for a review by the board under subsection 61(7.1);

“(b.3) prescribing additional practices and procedures for the purposes of subsection 61(8);

“(b.4) prescribing the qualifications or experience a member of the board is required to have in order to conduct reviews under subsection 61(8), 68(6) or 68.1(5);

“(b.5) respecting the making of complaints to a society under subsection 68(1) or to the board under subsection 68.1(1);

“(b.6) governing the complaint review procedure that societies are required to follow when dealing with a complaint under subsection 68(1);

“(b.7) prescribing matters for the purposes of paragraph 3 of subsection 68(5) and paragraph 6 of subsection 68.1(4);

“(b.8) prescribing additional orders that may be made by the board for the purposes of clauses 68(10)(c) and 68.1(7)(g);

“(b.9) prescribing practices and procedures for the purposes of hearings conducted by the board under subsection 68(8) or during a review of a complaint under section 68.1.”

The Chair: Any comments?

Mrs. Jeffrey: This motion deals with client complaints, decisions and supports. Essentially the Lieutenant Governor in Council will have authority to make regulations for some of the following issues: the practices and procedures for review of the Child and Family Services Review Board under section 61; the qualifications for board members conducting a review; the requirements for accessing the society's complaint process or making an application to the board respecting a complaint; and the procedures and practices the board must follow when reviewing a complaint under section 68.

The Chair: Any questions or debate on the motion? If there is none, I'll put the question. Shall the motion carry? Those in favour? Those against? It carries.

Shall section 41, as amended, carry? Those in favour? Those opposed? It does carry.

Section 42: page 73.

Mrs. Jeffrey: I move that clauses 220(1)(b.1) and (b.2) of the Child and Family Services Act, as set out in section 42 of the bill, be struck out and the following substituted:

“(b.1) governing applications for review under subsection 144(3);

“(b.2) prescribing additional practices and procedures for the purposes of subsection 144(7);

“(b.2.1) prescribing the qualifications or experience a member of the board is required to have in order to conduct reviews under subsection 144(8).”

This issue will deal with client complaints. The Lieutenant Governor in Council will have the authority to make regulations respecting applications for review under section 144, the practices and procedures for review by the Child and Family Services Review Board and the qualifications and experience for that board.

The Chair: Comments or questions? If none, I will now put the question. Shall the motion carry? Those in favour? Those opposed? It does carry.

Shall section 42, as amended, carry? Those in favour? Those opposed? It does carry.

Shall section 43 carry? Those in favour? Those opposed? Carried.

Mrs. Jeffrey: page 75.

Mrs. Jeffrey: I move that section 44 of the bill be struck out and the following substituted:

“44. Section 223 of the act is amended by adding the following clauses:

“(c) governing consultations with bands and native communities under sections 213 and 213.1 and prescribing the procedures and practices to be followed by societies and agencies and the duties of societies and agencies during the consultations;

“(d) prescribing services and powers for the purposes of section 213.1.”

Customary care is recognized in part X of the act and should be preserved as a traditional practice established and defined by First Nations. The leadership of Ontario First Nations has agreed to a process with the ministry to

develop best practice guidelines that will promote the expansion of customary care in Ontario.

The Chair: Any debate on the motion? If there is none, I will put the question. Shall the motion carry? Those in favour? Those opposed? It carries.

Shall section 44, as amended, carry? Those in favour? Those opposed? Section 44 carries.

Shall section 45 carry? Those in favour? Those opposed? It carries.

Section 45.1: Ms. Horwath, page 76, please.

Ms. Horwath: I move that the bill be amended by adding the following section:

“45.1 Part XII of the act is amended by adding the following section:

“Review re: aboriginal issues

“226. Every review of this act shall include a review of provisions imposing obligations on societies when providing services to a person who is an Indian or native person or in respect of children who are Indian or native persons, with a view to ensuring compliance by societies with those provisions.”

This was again recommended by First Nations communities. Their concern is that checks and balances be put in place to ensure that the requirement to consult and respect aboriginal provisions is in fact enforced.

The Chair: Is there any debate on the motion?

Mrs. Jeffrey: The minister met with many aboriginal leaders over the months and months of deliberations on this bill and they clearly indicated that the ministry should have regular review of the intent and effectiveness of the legislated obligations of the children's aid societies towards First Nation children, families and communities. Therefore, we support the motion.

The Chair: Any further debate? If there is none, I will take the vote. Those in favour of the motion? It carries.

Section 46, page 77: Mr. Leal.

Mr. Leal: I move that subsection 26(1.1) of the Children's Law Reform Act, as set out in subsection 46(1) of the bill, be struck out and the following substituted:

“Exception

“(1.1) Subsection (1) does not apply to an application under this part that relates to the custody of or access to a child if the child is the subject of an application or order under part III of the Child and Family Services Act, unless the application under this part relates to,

“(a) an order in respect of the child that was made under subsection 57.1(1) of the Child and Family Services Act;

“(b) an order referred to in subsection 57.1(2.1) of the Child and Family Services Act that was made at the same time as an order under subsection 57.1(1) of that act; or

“(c) an access order in respect of the child under section 58 of the Child and Family Services Act that was made at the same time as an order under subsection 57.1(1) of that act.”

The Chair: Any comments?

Mrs. Jeffrey: This amendment makes it clear that where there is an application under the CLRA to change or terminate a section 57.1 custody order or an access or restraining order, the orders should be dealt with as if they were made under the CLRA, and the delay provision would not apply. It's a housekeeping amendment.

The Chair: Any further debate? If there is none, I shall put the question. Shall the motion carry? Those in favour? Those opposed? The motion carries.

Shall section 46, as amended, carry? Those in favour? Those opposed? It carries.

Shall sections 47, 48, 49 and 50 carry? Those in favour? Those opposed? All of them carry.

Shall the title of the bill carry? Those in favour? Those against? It carries.

Shall Bill 210, as amended, carry? Those in favour? Those against? It carries.

Shall I report the bill, as amended, to the House? Those in favour? Those opposed? The motion carries.

I thank you all for being so efficient. We have dealt at this level with Bill 210, and I suspect today we will introduce third reading in the House. Thank you to staff and to all of you who participated, and to the people who watched us and commented. Thank you again.

The committee adjourned at 1220.

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Mrs. Julia Munro (York North / York-Nord PC)

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Clerk / Greffière

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